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Disability Policy and Disability Assessment System

In Latvia

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FINAL REPORT

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Acknowledgements

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Abbreviations

CRPD	UN Convention on the Rights of Persons with Disabilities
CSB	Central Statistical Bureau of Latvia
DIS	Disability Information System
EC	European Commission
E-Health	Single health information system
EHSIS	European Health and Social Integration Survey
ERDF	European Regional Development Fund
ESF	European Social Fund
EU	European Union
EU SILC	European Union Survey on Income and Living Conditions
EU LFS	European Union Labour Force Survey
ICD	International Classification of Diseases
ICF	International Classification of Functioning, Disability and Health
ILO	International Labor Organization
IRP	Individual rehabilitation plan
IT	Information technologies
LabIS	Welfare Information System
LAD	The Latvian Association of the Deaf
LSB	The Latvian Society of the Blind
MOES	Ministry of Education and Science
MOH	Ministry of Health
MOW	Ministry of Welfare
NRC "Vaivari"	State Limited Liability Company National Rehabilitation Center "Vaivari"
NHS	National Health Service
OCMA	The Office of Citizenship and Migration Affairs - institution responsible for issue of identity documents and travel documents, maintenance of the Population Register.
OECD	Organization for Economic Cooperation and Development
PES	Public Employment Service
SCI	Long-term social care and social rehabilitation institution
SISA	Social Integration State Agency
SMC	State Medical Commission for the Assessment of Health Condition and Working Ability
SPMC	State Pedagogical-Medical Commission
SRSP	Structural Reform Support Programme
DG REFORM	DG REFORM: Directorate General for Structural Reform Support
SSIA	State Social Insurance Agency
TS	Technical support
Vaivari TAC	Technical Aids Center of the National Rehabilitation Center "Vaivari"
WB	World Bank
WHO	World Health Organization

An overview

Report background

This Report was prepared as part of the project "Latvia - Disability assessment system development" implemented by the World Bank with funding from, and in collaboration with, the DG REFORM. The Project's aim is to support the Ministry of Welfare (MOW) of the Republic of Latvia in enhancing disability assessment. This will be achieved through technical support and advice to the MOW focusing on: (i) the design of a standardized assessment of functioning; (ii) the design, implementation and assessment of a pilot to test the inclusion of functioning into the disability assessment methodology in a standardized manner; and (iii) measures to strengthen linkages between disability assessment and labor market policies aimed at labor market inclusion of persons with disability. Efforts to strengthen the assessment of functioning (a lived experience of disabilities) follow the principles of the bio-psycho-social or interactional approach to disability of the World Health Organization's International Classification of Functioning, Disability and Health (WHO ICF; see also Annex 1 to this Report). This approach is reflected in the United Nations' Convention on the Rights of Persons with Disabilities (UNCRPD).[1]

In order to provide a base for the design of the functioning assessment pilot, a mapping of the current disability assessment system in Latvia was undertaken, including detailed description of the assessment criteria, the administrative/ business processes by means of which the disability assessment is conducted and the underlying information system that supports them. With a view to better understanding the policy environment in which the disability assessment system operates, the mapping also includes an overview of available disability data, a brief description of the legal provisions related to disability, and a description and assessment of both (i) support measures provided to persons with disabilities; and (ii) labor market and other programs to support employment of persons with disabilities. The mapping was undertaken by a large team of local and international experts (see Acknowledgements).

This Report presents an analysis and assessment of disability policy and its administration in Latvia. It comprises six chapters and 12 annexes. Each chapter concludes with a summary of findings and recommendations. Annex 12 lists the government officials interviewed for the report and sources of statistical information used for descriptive statistical analysis.

The Report begins with Disability *at a Glance*. This chapter, based on available data, presents disability prevalence and trends in Latvia between 2008-2018. It also includes disability assessment statistics. Data is disaggregated by age, gender, severity of disability and main health condition. More data is provided in Annex 2 to the Report. Chapter Two, *Disability Policy and System: Legal Framework*, presents key legislation on disability policies and institutions. Given the emphasis of the Report on the disability assessment system, the chapter focuses on legislation that covers the determination of disability and loss of ability to work and support to people with disabilities for their successful inclusion in society (namely, supports in health care, education, social security, and social care and employment services). *The purpose of this chapter is not to analyze legal provisions or to compare Latvia with other countries. Its purpose is rather to describe the current legal framework of disability policies and programs*. The list of laws and regulatory and administrative acts issued by the Cabinet of Ministers and other government agencies is presented in annexes 3 and 4 to this report. Chapter Three:

[1] Following the signing of the UNCRPD, Latvia undertook significant efforts to include the provisions of the Convention into its laws and regulations prior to ratifying the Convention in 2010. Since then, the laws have been continuously adjusted to help Latvia implement the Convention. The most important law establishing the framework for disability policies and programs is *The Disability Law*. Many other laws contain provisions specific to disabled people as well (see Chapters 2-5).

Disability Assessment System discusses the disability assessment system in Latvia, including disability assessment criteria and step-by-step administrative processes to implement them. Annexes 5-7 provide additional information on disability assessment. Chapter Four: *Support to Persons with Disabilities* presents an overview of disability benefits provided to persons with disabilities in Latvia. Annexes 8 - 10 provide additional information on these benefits. Chapter Five: *Labor Market and Persons with Disabilities* presents data on labor market participation of persons with disabilities, and discusses policies and programs aimed at fostering it (see also Annex 11 to this Report). Finally, Chapter Six – *An Overview of Recommendations* lists, for easy reference, recommendations provided throughout chapters 1-5.

Below, we summarize key messages from the Report. For detailed findings and recommendations, we refer the reader to the final sections of Chapters One to Five and to the Chapter Six that presents a list of all recommendations by chapters.

Key messages

Context

Latvia's rate of disability has grown fast. According to administrative data from the State Medical Commission, Latvia's rate of disability was 10.0 percent of the population in 2018, a 50.0 percent increase relative to 2008. or 5.0 percent on average per annum. The European Union Survey of Income and Living Conditions reports that in 2018 about 40.0 percent of the population self-reported "experiencing long standing limitations in usual activities due to health problems" – the highest in the EU and an increase of 27.0 from 2010 when this estimate was 31.4 percent. More women than men experience disability. Disability is more prevalent among elderly population and severity of disability is strongly associated with age. Malignant neoplasms, diseases of circulatory system, musculoskeletal diseases and neurodevelopmental disorders are prevalent diseases associated with disability.

Sharply growing increase in disability prevalence can in part be associated with the aging of the Latvian population: between 2009 and 2019 the share of elderly population (older than 65) increased from 18.0 to 20.34 percent, or 13.0 percent and the share of the working age population (15-64 years of age) dropped from 68.0 to 63.4 percent. The share of 65+ is projected to increase to 25.0 percent by 2030 and old-age dependency ratio from 34.5 in 2019 to 46.4 in 2030. Other socio-economic determinants of health and disability such as the health status of the population, morbidity patterns, environmental and other barriers to functioning and participation persons with a health condition may experience, lifestyle choices and habits, physical activity, access to and quality of health care and support services, income, employment, education, all must have played a role too.

Given that aging has been found to be associated with increased rates of disability, **disability rates are expected to increase** as well.[2] This is important, since the Latvian population is shrinking (Latvia has a low fertility rate of 1.34) and aging (UN projects that Latvian population will decline to 1.48 million by 2050 and the median age of the population will increase due to low fertility and growing life expectancy), inevitably resulting in a growing share of elderly in the total population. ***Latvia would need an in-depth study to determine which factors are driving the disability rate up and to what extent.***

[2] It is an empirically established fact that as humans age, their bodily capacity to function deteriorates. However, in many countries, the rates of persons with disabilities with formally determined disability status pertain only to working age population. Latvia is among countries where disability status and support through disability system is provided to all persons experiencing disabilities, irrespective of their age. This approach enables Latvia to more accurately establish the rates of disability in its population and, thus, to plan disability policies adequately.

As many other countries that are experiencing the aging of the population, Latvia ought to start preparing and planning for a future in which a significant fraction of the population will be elderly, many of whom will be experiencing difficulties in functioning and disability. Focusing on prevention, and healthy leaving and aging, as well as on policies to support functioning and participation, including staying in the labor market for as long as individuals can and are willing to, are key to mitigate the social and economic impact of an aging population increasingly experiencing disability.

In planning for the future, the disability assessment system, public support programs to persons with disabilities and policies and programs to foster their labor market inclusion play a very important role. They can be powerful facilitators in preventing and reducing the risk of disability and in strengthening functioning and the participation of persons with disabilities for greater individual and societal well-being.

Before we present the Report's key messages regarding the disability assessment system and public support programs to persons with disability, including policies and program to foster their labor market inclusion, it should be noted that ***following the signing of the UNCRPD, Latvia undertook significant efforts to include the provisions of the Convention into its laws and regulations prior to ratifying the Convention in 2010. Since then, the laws have been continuously adjusted to help Latvia implement the Convention***. In general, following the ***principles of mainstreaming, equal treatment and non-discrimination***, in most relevant legislation persons with disabilities are not singled out as a specific group: they have the same rights as everyone else. At the same time, where appropriate, persons with disabilities are entitled ***to disability-specific government benefits and services***.

Disability Assessment System

The disability assessment or certification process[3] is a gate through which anyone who wishes to be formally recognized as a person with disability and to claim any publicly provided disability related benefit, service or product is required to pass. Every country has some form of disability assessment and some government authorized agency or agent charged with assessing whether a person is disabled or not, and to which degree. In Latvia, the assessment is performed by the State Medical Commission for the Assessment of Health Condition and Working Ability (SMC). Most commonly and visibly disability assessment is linked to disability social insurance benefits. But it also applies to eligibility for other social policy benefit: to access these benefits—from rehabilitation services, to care services, to assistive devices, to disability social pension, to social assistance in cash and in kind—people must be officially recognized to have a disability. Disability assessment affects labor supply, government spending and individual welfare.

Disability assessment criteria reflect the predominant understanding of disability. Hence, until the 2000s, the criteria have been based almost solely on medical approach to disability: the determination of the existence and extent of 'disability' is made based entirely on medical information about health conditions, morbidity and/or resulting impairments. This is the oldest and still most commonly used strategy.[4] The formulation of the new approach to disability by the WHO ICF in 2001[5] – the bio-psycho-

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[3] Bickenbach B, Posarac A, Cieza A, Kostanjsek N (June 2015). ***Assessing Disability in Working Age Population - A Paradigm Shift: from Impairment and Functional Limitation to the Disability Approach***. Report No: ACS14124, World Bank, Washington, D.C. 2015.

[4] One of the still most commonly used assessment tools is the so called Barrême Table or Grid, named after the French mathematician François-Bertrand Barrême, who invented it in the late 17th Century - a list of impairments and diagnoses paired with associated percentages of disability.

[5] World Health Organization (WHO). 2001. *International Classification of Functioning, Disability and Health*. Geneva. The new approach to disability was unanimously approved by the WHO Assembly in 2001. This approach understands disability as a consequence of interaction between a person with a health condition and his or her environment. It has introduced concepts of functioning, intrinsic capacity, capacity to perform life activities and to participate in society as important aspects in

social or interactional approach to disability, and the adoption of the UNCRPD has prompted many countries to reflect this new approach to disability into their disability assessment processes.

Latvia has made significant changes to its disability assessment system as of January 1, 2015, by moving from an assessment based solely on medical condition to an assessment that follows the WHO ICF, and therefore takes into account functioning, or the lived experience of persons with disabilities. This is an extremely important paradigm shift in approaching disability and is in line with the UNCRPD. To that end, (i) criteria for disability assessment were partially changed by selecting a sample of ICF items from body functions and activities and participation to guide the assessment, (ii) a self-assessment of functioning was introduced; and (iii) as care needs tool, the "Questionnaire of Assessment of Everyday Activities and Environment of the Person" filled out by a social worker or occupational therapist was developed. The assessment has become entirely based on the review of documents, without a face-to-face interaction, on the assumption that information provided by a physician and a self-assessment form would be enough for an expert assessor to assess the state of health and functioning of a person and determine her/his disability and work capacity, as well as care need.

The medical to functioning shift is yet to take place. Although changes to the regulatory framework have been made with the aim of increasing the importance of functioning in disability assessment, in practice, the change has been slow. Disability, severity of disability, loss of capacity to work are determined largely according to medical diagnosis, information provided by the medical practitioner on the health status of the person, medical examinations and consultations.

The pace and depth of change critically depend on the operationalization and tools and resources to implement it. Legally, disability, severity of disability and work ability are to be assessed based on the functioning restrictions a person with a health condition experiences in her/his life. However, criteria stipulated for disability assessment are not commensurate with the legal framework, there are inconsistencies between them and there is discrepancy between the criteria and information requested from medical doctors. For instance, for occupational accidents and diseases, disability is determined based on diagnosis and impairments and associated percentage of loss of work capacity (a traditional Barreme grid). The domains of functioning included in the criteria are a small sample from a much larger ICF list and it is not clear how the choice of those items was made. Moreover, it is not clear who makes an assessment, for example, of the extent, lightness and stability of joint movements, or muscle strength by scores, or memory function or what tools are used for this purpose, particularly in the case when disability is determined for the first time.

Predictable disability is determined rarely: a missed opportunity to focus on rehabilitation and improvements in functioning. The Latvian law recognizes both predictable disability and disability. The state supports the access to medical care and medical rehabilitation services for people who have been recognized as having a predictable disability, and these supports are insignificant. They are entitled to medical rehabilitation services on a priority basis, based on their individual rehabilitation plans, but these are often not immediately available, and the waiting lists are long. As a result, people opt to receive an extended sick leave based on the SMC's opinion (up to another 26 weeks) or a disability status, rather than a predictable disability. In many ways, the currently insignificant role of predictable disability is a missed opportunity, particularly for employed, working age adults. Except for obviously severe cases, the predictable disability (and, if needed, combined with an extended sick leave) is an opportunity during which SMC, rehabilitation professionals, employment service, employers, local social services and MOW can come together to support a person to recover and stay

determining the presence and extent of disability. This approach to disability was espoused by the United Nations Convention on the Rights of Persons with Disabilities (2008).

in employment. As evidenced by many studies, once a person leaves the labor market due to disability, the chances of getting back into the labor market are small.

SMC needs significant strengthening. The SMC staff are aging, and the job is not attractive enough to draw young medical graduates. The work is not considered prestigious and the pay is not competitive. There are no occupational physicians and rehabilitation professionals are in short supply. This problem would need to be addressed by a multi-pronged approach, including (i) requiring medical schools to offer courses on the ICF, disability and its measurement and assessment, etc.; (ii) having SMC in cooperation with Ministry of Health (MOH) offer stipends to rehabilitation medicine students to spend several years working at SMC; (iii) develop and implement on-boarding and other training courses in functioning and disability on an annual mandatory basis; (iv) incentivizing SMC staff to do research using SMC data (once it is available electronically). Face-to-face interviews would increase the job attractiveness, as medical doctors are trained to work with people, not paper.

Disability information system and data on disability

The existence of a comprehensive disability information system within SMC and an overall system to collect data on disability is crucially important not only for an efficient and effective disability assessment system, but also for evidence-based development of disability policies and analyses and research on disability. ***Latvia has many elements of disability data collection, but it is yet to achieve a comprehensive and integrated disability information system.***

The current SMC Disability Information System (DIS) was developed in 2006, with upgrades in 2011 and 2015. However, relative to actual needs and requirements, it is outdated, and it does not comply with the good practice of the personal data processing regulations. In addition, most of the information collected through the process of disability assessment (e.g. self-assessment of functioning questionnaires) are not automated and cannot be used to compare and analyze the self-assessment, medical information and the decision on disability. The automatic exchange of information with other agencies is rather limited. Some information is not collected, although information such as whether persons applying for disability plan to stay in employment, and so on could be extremely valuable. Currently, there is an ongoing project to significantly update and upgrade the SMC DIS (2019-2022).

Ultimately, all SMC business processes should be automated, with electronic handling of documents, an electronic archive system, and automated data exchange with other government data bases, including E-Health, civil registry, State Social Insurance Agency (SSIA), local governments. As a rule, all data about an individual used in the disability assessment system should be entered into the DIS and available for future assessments; but the information can also be used for research in anonymized format when crosschecked with data in the MOW *Welfare Information System*.

On a more general basis, Latvia does not have a single information system that would allow MOW to monitor benefits provided to persons with disabilities by each individual from all institutions that provide some support to persons with disabilities. Data base *Welfare Information System* hosted by MOW and SSIA, stores data on social insurance and state allowances, as well as information from the Public Employment Service (PES), SMC, and social assistance provided by local governments. But information related to the provision of services by municipalities is lacking.

Support to persons with disabilities

Latvia features a comprehensive array of support measures to persons with disabilities, from social insurance to state allowances to services. Almost all persons with disabilities receive at least one form of support. Social insurance programs dominate (disability pension and benefits in case of work accident or occupational disease), followed by a menu of state allowances in cash to assist with

transport expenses, social care, services of an assistant, sign language interpretations, etc. Benefits in cash dominate. Social care services are nascent and provided to a small fraction of persons with disabilities. Here, institutional (residential) forms of care are prevalent and community-based care is only at the very beginning of its development. Vocational rehabilitation and medical rehabilitation services are available although limited as is the provision of technical aids. In addition, other support measures outside social support are available to large share of persons with disabilities, including free public transport, lower electricity tariffs, discounts on vehicle insurance and road tolls.

Spending on disability benefits is low and Latvia has one of the lowest spending relative to GDP of EU countries. Low spending implies low benefits. The benefits in cash are almost uniformly low, except for benefits in case of work accident and occupational disease. There are no indexation rules yet (changes to the legislation are expected to come into force as of January 2021), and some benefits have stayed unchanged for years, while some were reviewed recently (e.g. special care needs benefits for persons with disability since childhood). Access to services like medical and vocational rehabilitation and technical aids is rationed through long waiting times.

The benefit levels seem to be a function of allocated budget rather than some **established** ***methodology with benchmarks***. It is difficult to understand how the differentiation of benefits according to the severity of disability is decided on. While a focus on benefits in cash is understandable, limited provision of services calls for a hard look at the composition of support measures. Also, the demand for some benefits (e.g. benefits in case of accidents and services of an assistant) has recently increased significantly, which calls for a closer scrutiny to understand the reasons behind the spike in demand.

Latvia does not have an established holistic, multidisciplinary method and process to assess the needs of persons with disabilities. Except in the case of three benefits and services for which an opinion of SMC is required, whether to apply for the benefits and services is a decision of the person, once certified as disabled. This approach works in favor of those who are better informed, are able to collect all required documents and have time to submit multiple applications.

To access disability benefits, a person must be certified as disabled. However, if the objective of disability policy is to optimize functioning and ensure labor force participation, many benefits should also be provided prior to the certification, including medical and vocational rehabilitation, labor market programs, and assistive and technical aids. Latvia has very good sick leave provisions and the sick leave, especially the extended period after the first 26 weeks could be used for interventions to prevent or reduce disability. To prevent and reduce disability, however, the sequence of support measures provision would need to be rethought.

Despite having an array of disability benefits, these benefits do not form a continuous range of programs that are focused on optimizing functioning and maximizing participation. The brief overview of disability support measures in this chapter gives the impression of certain fragmentation rather than coherence. Many state cash allowances seem to be geared towards material support -- an allowance for care, an allowance for transport expenses, etc. A different approach would be to first increase the level of a disability pension (and the state social security benefit), which is currently very low, and then provide a supplement that would reflect the costs of living with disability to provide for the needs of a person. This approach, however, would require a different needs assessment and a new sequencing of support measures and disability certification. Structural imbalances are obvious, especially concerning services, which are underdeveloped and dominated by institutional care.

The practice of regular systematic assessment of programs and their performance is yet to be adopted. Any program should be subject to a periodical systematic assessment to inform the program adjustments. Programs not meeting their objectives should be discontinued.

Supporting labor market inclusion of persons with disabilities

Based on administrative data, Latvia has low labor force participation, low employment (even among Group III disability, only half are employed) and high unemployment rates of persons with disabilities. Comparatively speaking, as shown in Figure 5.7 in Chapter Five, the rate of unemployment stands out relative to other countries. Most of persons with disabilities of working age (about two thirds) do not participate in the labor market. For a rapidly aging country, this is a challenge that would need serious consideration, if not in the short-, then in the medium-term. It would also require an orientation of disability policy, including labor market support towards supporting persons with disabilities staying in employment, irrespective of their disability status. In other words, employment support should start well before a person undergoes disability assessment and it should be part of an integrated continuous effort to optimize functioning, activity performance and participation (including staying at work) of persons experiencing difficulties in functioning and disability.

To benefit from active labor market policies for persons with disabilities, a person with a disability must be certified as disabled and registered as an unemployed person with PES. A person can go to PES without disability assessment as well, however he or she will not benefit from those measures where disability is an eligibility criterion. About half of persons with disabilities who find employment do so without assistance from PES. Long term unemployed persons with disabilities, those nearing retirement and those with low or no qualifications tend to register with PES. Spending on active labor market programs is almost negligible and there are no programs to support persons with disabilities stay at work.

Like other disability policies, active labor market programs for persons with disabilities are set up almost in isolation from other policies aimed to optimize functioning of persons with disabilities and maximize their activities and participation. This is one of key issues with disability policies in Latvia: programs rarely talk to each other – they are not viewed as part of a range and continuum of services, rather, they are delivered as separate programs to persons who request them at their personal initiative and manage to meet eligibility requirements.

In Latvia, a comprehensive, multidisciplinary assessment of needs of persons with disabilities matched with the service provision plan is lacking, contributing to institutional turfs, fragmentation, overlaps, inefficiencies and suboptimal results. Periodic evaluation and impact assessments are lacking, and it is hard to say anything about the impact of any program, including active labor market programs.

Data on labor market participation of persons with disabilities are rather basic and do not allow for a more comprehensive analysis. For instance, there is no information about labor market status of persons who get certified as disabled for the first time: do they keep working, do they work part time, do they leave employment permanently or temporarily, would they want to continue working but in a different job with the same employer, etc. Collecting these pieces of information could be invaluable for designing and planning labor market policies targeted at persons with disabilities. Moreover, acting early, while persons are still on a sick leave may help many keep their jobs, even after they have been certified as disabled. This would be much more effective than setting up employment quotas for persons with disabilities, which we assess as not likely to have any impact on employment of persons with disabilities.

1. DISABILITY AT A GLANCE

We begin the study with the Disability at a Glance chapter. Here, based on available data, we present disability prevalence and trends in Latvia between 2008-2018. We also look at disability assessment statistics. Data is disaggregated by age, gender, severity of disability and main health conditions.[6] More data is provided in Annex 2 to this Report.

Photo credit: MOW, Social campaign "A Person Not A Diagnosis" (2018) - https://cilveksnevisdiagnoze.lv/en/

1.1 Disability prevalence and trends

To look at disability prevalence and trends in Latvia, we use three currently available sources of data: (i) the 2008-2018 administrative data from state records, mostly from the State Medical Commission for the Assessment of Health Condition and Working Ability (SMC) and from the State Social Insurance Agency (SSIA); (ii) Eurostat data from the European Union Survey on Income and Living Conditions (EU SILC) – 2008-2018; and (iii) data from a one-off European Health and Social Integration Survey (EHSIS) from 2012. While EHSIS data are from 2011, they provide some interesting insights into disability in Latvia and other EU countries. With EHSIS we also present some results from the 2011 ad hoc module of the European Union Labor Force Survey (EU LFS) on the employment of persons with disabilities.[7]

[6] Further detailed data on disability is provided in Annex 2 to the Report.

[7] EU SILC, EHSIS and EU LFS data sets are available on the Eurostat web site – data and database: https://ec.europa.eu/eurostat/data/database

Disability is a complex, evolving and multi-dimensional concept and population surveys and other sources of data may use various definitions, interpretations and approaches to try to measure it. While the temptation is great to compare Latvia's disability rates based on administrative, EU SILC and EHSIS data, it is not advisable to do so as these data sets are not directly comparable. They capture and measure different aspects of disability and any comparisons would require an in-depth analysis with plenty of caveats.

As noted,

(i) Administrative data on persons with disabilities (children, adults and the elderly) concern individuals of all ages who have been assessed by SMC and have been formally certified as persons with disabilities.
(ii) EU SILC presents data collected with a population survey in which individuals 16 years of age or older have self-reported "long-standing limitations in usual activities due to health problems".
(iii) EHSIS (2012) surveyed a population 15 years of age and over. It captures people facing barriers to participation in different life areas, in conjunction with a long-standing health problem and/or a basic activity difficulty[8]. The EHSIS approach to disability and its measurement draws upon the bio-psycho-social or interactional model of disability developed and adopted by the World Health Organization (WHO) and found in the International Classification of Functioning, Disability and Health ICF).[9]
(iv) EU LFS covers people of working age – 15-64. The 2011 *ad hoc* module on disability captures people reporting a basic activity difficulty (such as difficulty in seeing, hearing, walking or communicating). Disability in employment is defined as being limited in work because of a long-standing health problem and/or a basic activity difficulty.

1.1.1 Administrative data

According to **administrative data** from the SMC, there were in Latvia in 2018 192,887 persons of all ages with formally-determined status of disability (that is, people who had gone through a disability assessment process and were certified as having a disability) -- 10.0 percent of the Latvian population. Compared to 2008, the number of persons with disabilities has increased by 50.3 percent or 5.0 percent per year on average (Figure 1.1).[10] In 2008, there were 128,335 persons with disability or 5.9 percent of the total population of 2.192 million. The disability rate has grown from 5.9 to 10.0 percent

[8] EHSIS questionnaire covers: (i) the socio-economic background (classificatory questions); (ii) a health component (Minimum European Health Module) and a list of groups of longstanding health conditions; list of limitations in basic activities: seeing, hearing, walking, …; activities of daily living (ADL: self-care activities such as feeding oneself, dressing, and bathing); and instrumental activities of daily living (IADL: domestic life activities, such as managing money, shopping, using the telephone, and housekeeping); and (iii) ten areas on environmental factors that enable an individual to be a fully functional and integrated member of society (transport, accessibility of buildings, education and training resources, employment, access to internet use, social contact and support, access to leisure pursuits, economic life, attitudes and behavior. For each of these areas, disadvantages in and restrictions to social participation that people (with and without a longstanding health problem or a basic activity difficulty) face in their everyday lives were investigated. See: Prevalence of disability (source EHSIS) (hlth_dsb_prve); Reference Metadata in Euro SDMX Metadata Structure (ESMS); Compiling agency: Eurostat, the statistical office of the European Union.
https://ec.europa.eu/eurostat/cache/metadata/en/hlth_dsb_prve_esms.htm

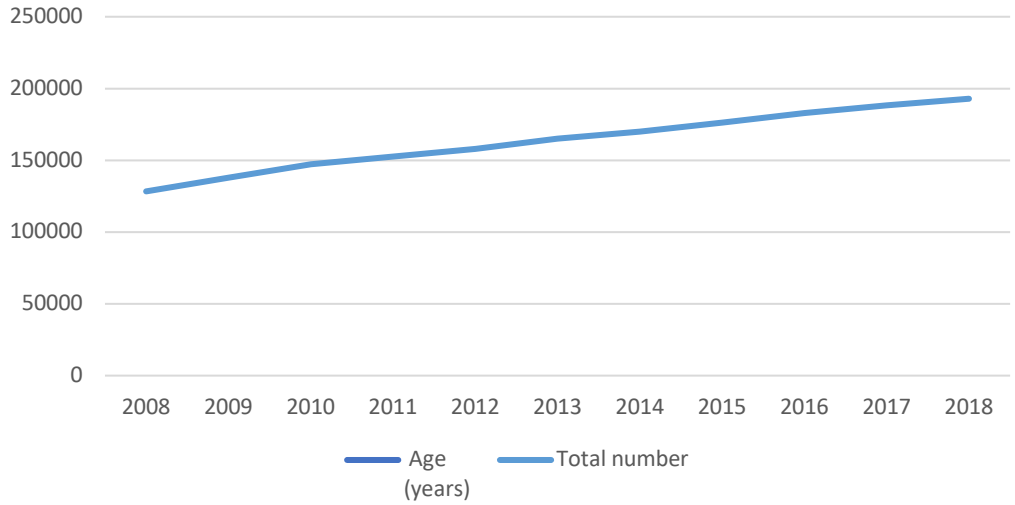
[9] ICF is the WHO classification for measuring health and disability at both individual and population levels. ICF was officially endorsed as the international standard for describing and measuring health and functioning by all 191 WHO Member States at the Fifty-fourth World Health Assembly on 22 May 2001 (resolution WHA 54.21).
See https://www.who.int/classifications/icf/en/

[10] It would be useful to compare administrative data on the numbers of persons with disabilities internationally. But these data are rarely available. Moreover, whatever data can be found are not comparable, since administrative data reflect disability assessment systems, as well as benefits provided to persons with disabilities, which differ widely

or 69.5 percent – faster than the increase in the population, reflecting a decline in the Latvian population of almost 12.0 percent between 2008 and 2018.

At a 5.0 percent average annual increase rate, the number of persons formally recognized as disabled is growing quickly in Latvia. It is beyond the scope of this study to analyze the reasons for this growth. Such an analysis would require comprehensive data on factors believed or determined to be associated with trends in disability prevalence, including population aging, gender, lifestyle choices, income level, access to and quality of health care and support services, level of physical activity, and changes in disability assessment system and its criteria[11]. Given the impact on social and economic policy and the labor market of high rates of disability, the MOW should consider conducting such a study.

Figure 1.1 - Persons with disabilities in Latvia 2008-2018



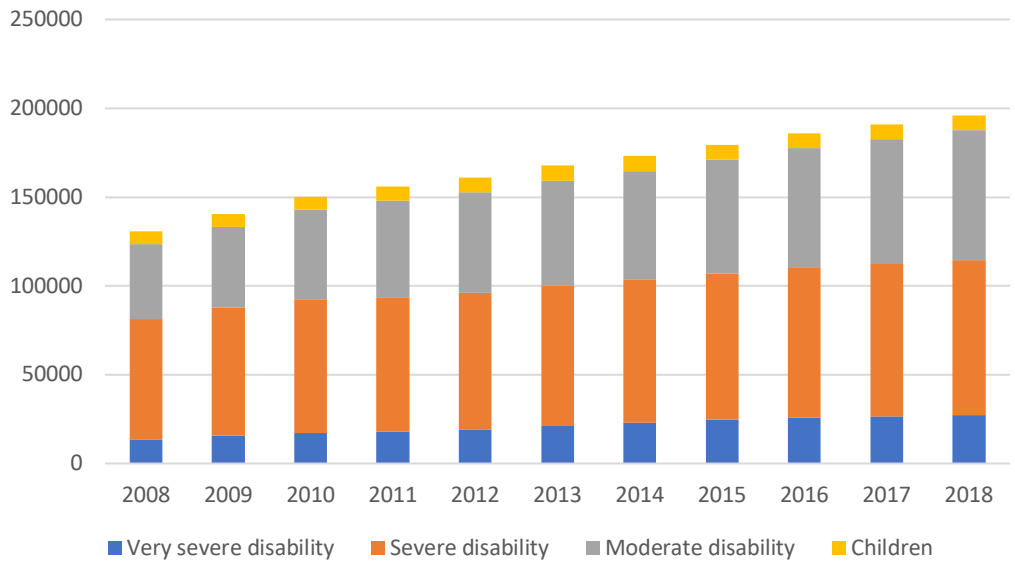
Source: SMC

Trends in disability prevalence by severity of disability 2010-2018 are presented in Figures 1.2-1.4. Since disability for children is not divided into groups of severity, children have been added to the data as a separate group. The trends are summarized below:

- There were 8,312 children with disabilities in 2018 – about 15.0 percent increase since 2008. Their share in the total number of persons with disabilities decreased from 6.0 to 4.0 percent. Their share in total population increased from 0.35 to 0.4 percent due to the decline in the population.
- The number of persons with very severe disabilities (Group I) almost doubled between 2010 and 2018 – from 14,000 to 27,000 persons. Their share among persons with disabilities increased from 11.0 to 14.0 percent and in the total population from 0.64 to 1.4 percent.

[11] See, for example, "Informative Report on the Implementation of the UN Guidelines on the Rights of Persons with Disabilities in Latvia in 2014-2020, Mid-term Evaluation" ("Informatīvais ziņojums Apvienoto Nāciju Organizācijas Konvencijas par personu ar invaliditāti tiesībām īstenošanas pamatnostādņu 2014.–2020.gadam vidusposma novērtējums"): http://polsis.mk.gov.lv/documents/6394. Generally speaking, data on disability are scarce; data that would allow for international comparisons even more so. This situation was extensively discussed in Chapter Two of the 2011 World Health Organization & World Bank (WHO/WB) World Report on Disability (https://www.who.int/disabilities/world_report/2011/report.pdf).

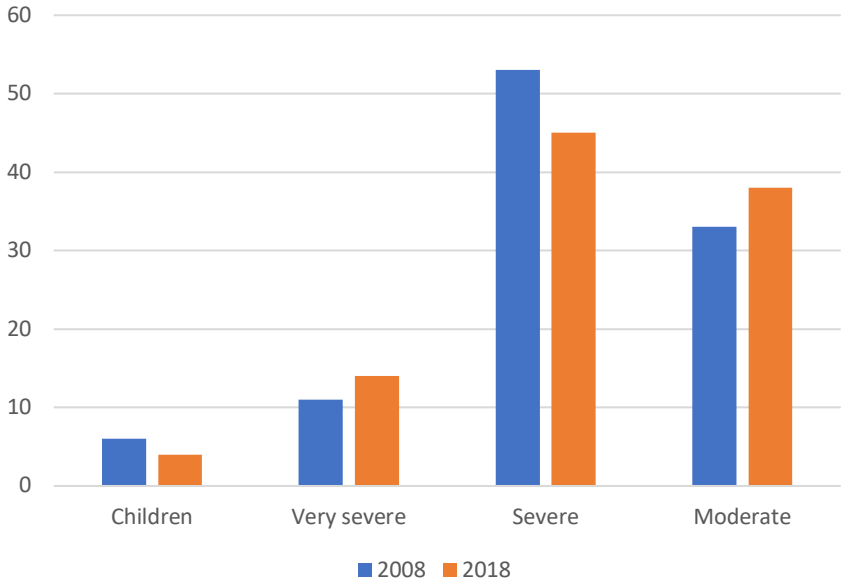
Figure 1.2 - Persons with disabilities by severity 2008-2018 (in percent of the total)



Source: SMC

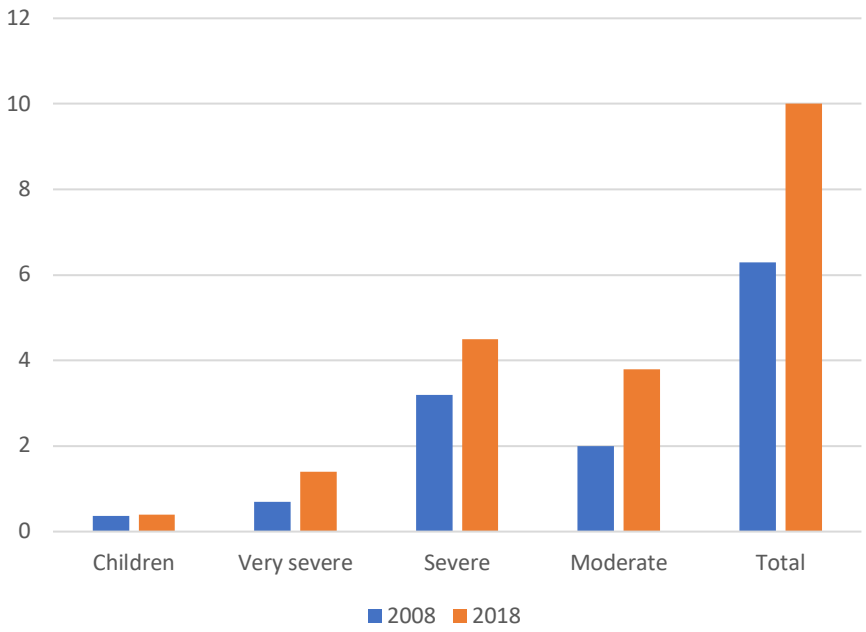
- The number of persons with severe disabilities (Group II) – the largest disability group -- increased from 68,000 to 86,800. Their share among persons with disabilities decreased from 53.0 to 45.0 percent, while their share in the total population increased from 3.1 to 4.5 percent.
- Finally, the number of persons with moderate disability (Group III) increased from 42,350 to 73,300. Their share among persons with disabilities decreased from 53.0 to 45.0 percent, while their share in the total population doubled - from 1.9 to 3.8 percent.

Figure 1.3 -Persons with disabilities by severity of disability 2008-2018
(in % of the total number of persons with disabilities)



Source: SMC.

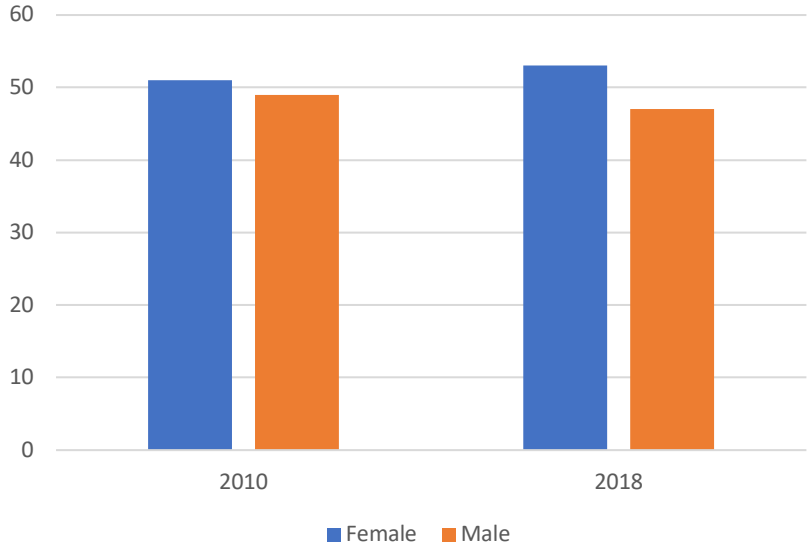
Figure 1.4 -Persons with disabilities by severity of disability 2010-2018
(in % of the total population)



Source: SMC.

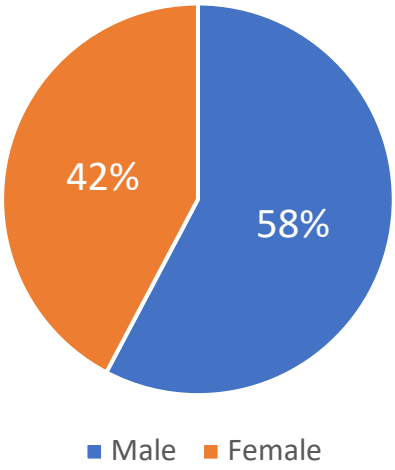
Women make up more than half of the total number of persons with disabilities and their share has slightly increased over 2008-2018: from 51.0 to 53.0 percent (Figure 1.5). In contrast, among children with disabilities boys have a higher proportion: 58.0 percent (Figure 1.6).

Figure 1.5 -Disability in Latvia: gender composition (% of the total)



Source: SMC.

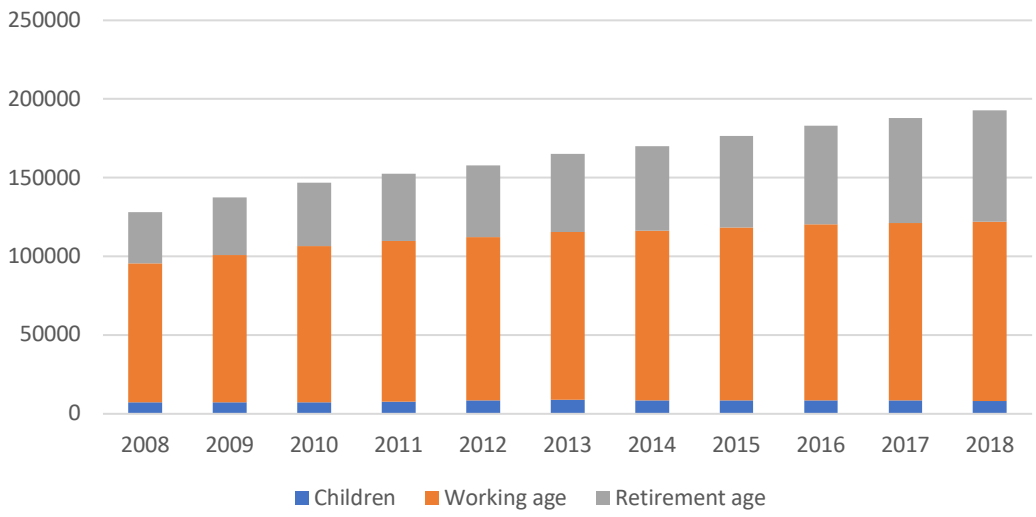
Figure 1.6 -Children with disabilities by gender, 2018



Source: SMC.

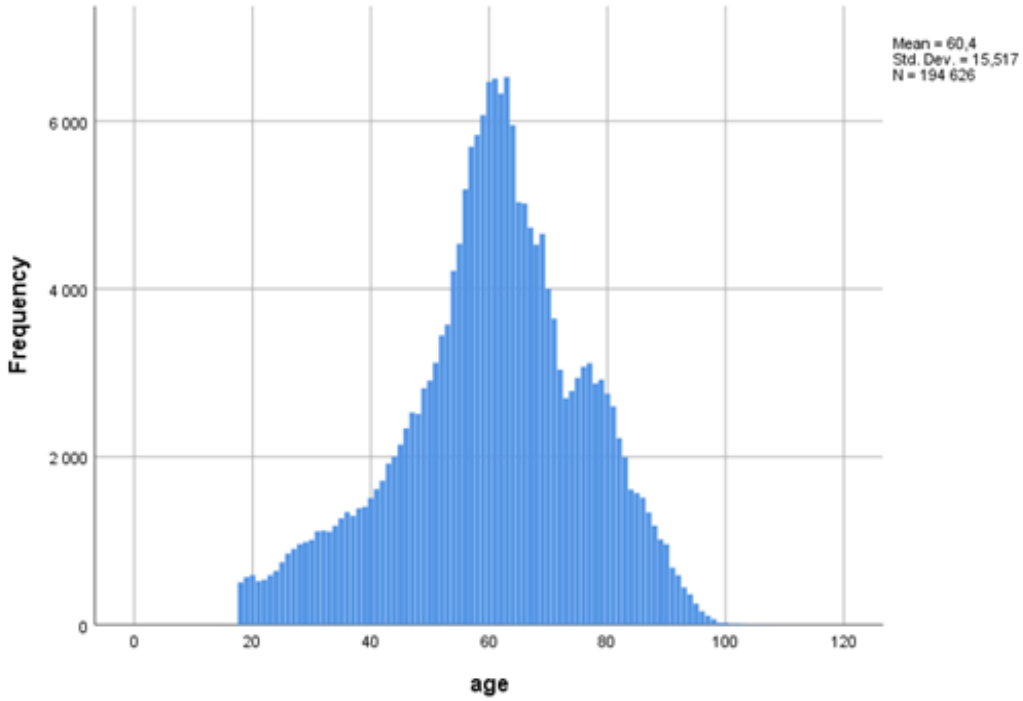
Figures 1.7 and 1.8 present persons with disabilities by age. The following age groups are used: Children <18 years; working age persons with disabilities 18 – 64 years, and elderly/retired >65 years. Figure 1.7 shows that, as noted above, the number of children with disabilities remained relatively stable in the period under observation (see brief discussion on children with disabilities below). However, there has been a significant shift between the working age persons with disabilities whose relative share in the number of persons with disabilities has been shrinking, while that of elderly persons with disabilities has been steadily increasing, reflecting the overall aging of the Latvian population. While in 2008, the relative shares of these two groups were 69.0 and 25.0 percent, in 2018 the respective shares were 59.0 and 37.0 percent.

Figure 1.7 -Persons with disability in Latvia by age groups 2008-2018 (in absolute numbers)



Source: SMC.

Figure 1.8 -Persons with disabilities by age (2018)

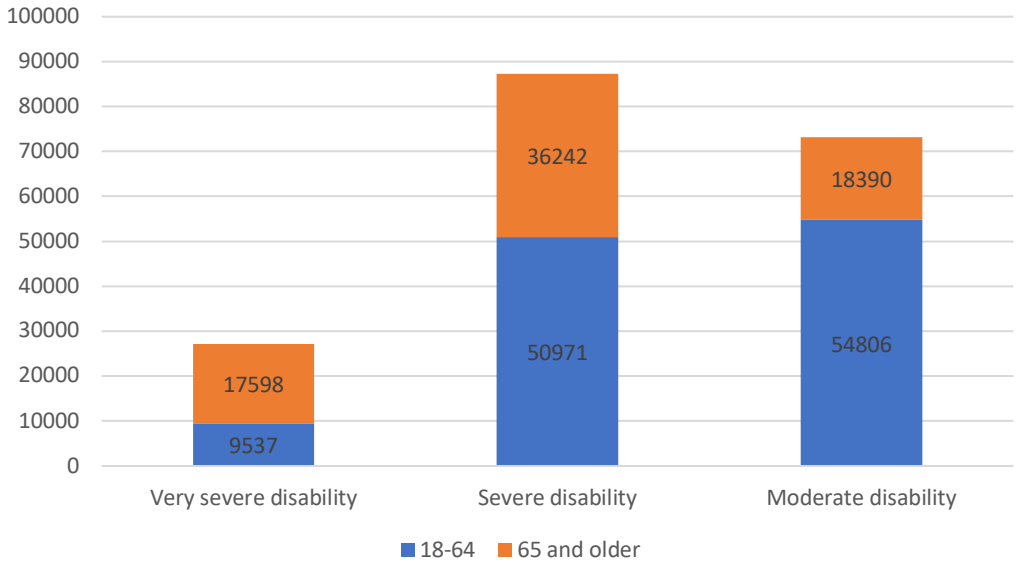


Source: SSIA.

Data from the SSIA on the age distribution of persons with disabilities older than 18 years of age show that the number of persons with disabilities steadily increases with age, reaching the peak at the age group 55-65, after which the numbers decline until late 70s when there is another peak. After the late 70s, the numbers decline, which is expected due to increased mortality.

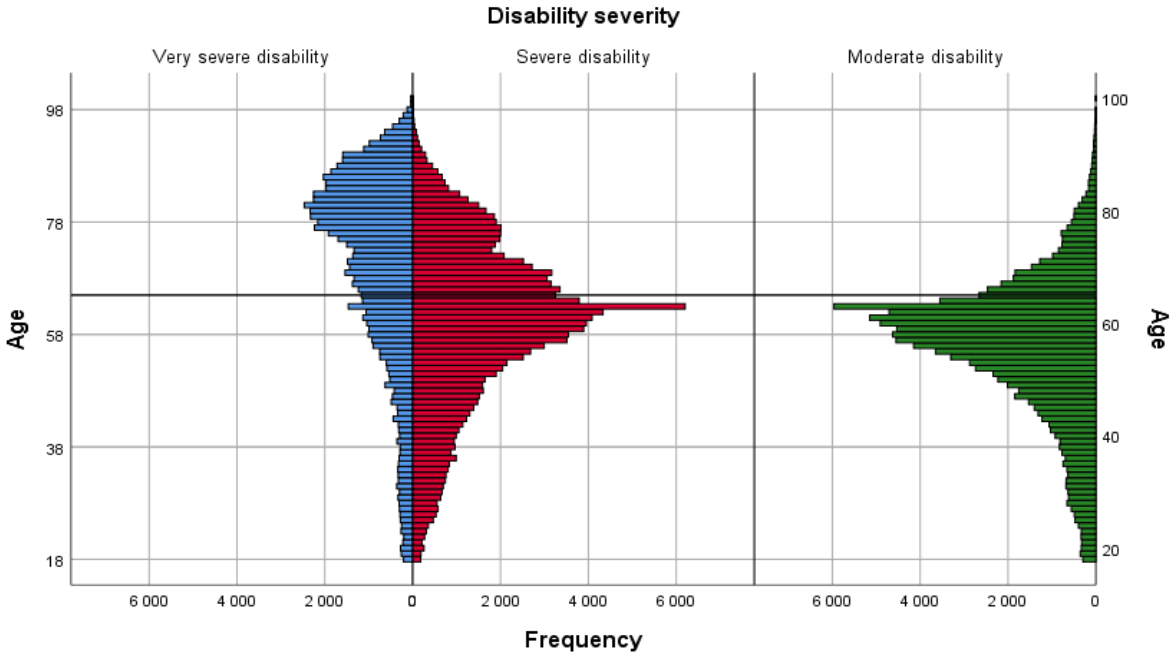
According to data from the SMC, most persons with very severe disability (Group I) are over the age of 65, and most persons with moderate disability (Group III) are in working age (see Figure 1.9). This is also supported by data from the SSIA (Figure 1.10).

Figure 1.9 -Severity of disability by age (2018)



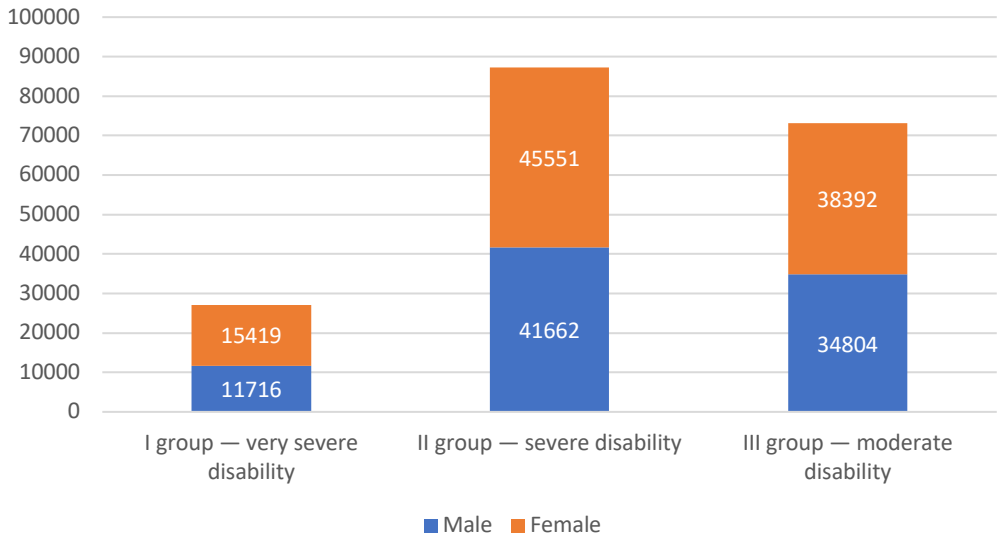
Source: SMC

Figure 1.10 - Persons with disability – age distribution by severity of disability (2018)



** Reference line – 65 years*
Source: SSIA

Figure 1.11 -Severity of disability by gender (2018)



Source: SMC

There are slightly more females in all disability groups (Figure 1.11). This is not surprising, since 54.0 percent of Latvian population is female and this proportion increases with age (CSB, 2018).[12]

[12] Central Statistical Bureau of Latvia. (2018). *Demography 2018. Collection of Statistics.* Retrieved from: https://www.csb.gov.lv/en/statistics/statistics-by-theme/population/number-and-change/search-in-theme/301-demography-2018

1.1.2 EU SILC data

Another source of data on disability prevalence in Latvia is the **EU SILC**. In this survey, disability is defined as "long-standing limitations in usual activities due to health problems". The data are self-reported. As presented in Table 2.1, EU SILC data for 2018[13] show that in the EU Latvia had by far the highest rate of persons 16 years and over experiencing "long-standing limitations in usual activities due to health problems": 40.0 percent (30.3 percent "some" and 9.7 "severe" limitations). This is more than a 60.0 percent higher rate compared to the EU-28 average: 24.7 percent (17.7 percent and 7.0 percent respectively). As in other European Union countries, prevalence of self-reported limitations is higher among females than males, sharply increases with age and is inversely related to the income level.[14]

Table 1.1 - Persons self-reporting long standing limitations in usual activities due to health problems in EU in 2018

Distribution of persons by self-reported long-standing limitations in usual activities due to health problems, by sex, 2018

(% share of the population aged 16 and over)

	Total			Males			Females		
	Some	Severe	None	Some	Severe	None	Some	Severe	None
EU-28 (1)	17.7	7.0	75.3	15.9	6.4	77.8	19.4	7.6	73.0
Belgium	16.5	8.9	74.7	15.5	7.5	77.0	17.4	10.2	72.5
Bulgaria	13.0	3.7	83.4	10.8	3.3	85.9	14.9	4.0	81.1
Czechia	20.2	7.7	72.0	18.3	6.9	74.7	21.5	8.3	70.2
Denmark	23.2	5.8	71.0	20.4	5.0	74.7	25.9	6.6	67.5
Germany	15.1	7.1	77.7	14.4	6.8	78.7	15.8	7.4	76.8
Estonia	26.8	12.7	60.5	25.7	10.4	63.8	27.6	14.4	58.0
Ireland (2)	11.4	5.6	83.0	11.0	5.4	83.6	11.7	5.7	82.6
Greece	13.6	10.2	76.2	12.5	9.3	78.2	14.6	11.0	74.5
Spain	16.2	4.4	79.4	13.9	3.8	82.2	18.4	4.9	76.7
France	15.9	9.3	74.8	14.7	8.6	76.8	17.0	10.0	72.9
Croatia	23.3	10.1	66.6	22.2	9.0	68.7	24.4	11.0	64.6
Italy	18.2	5.5	76.3	16.2	4.7	79.1	20.1	6.3	73.7
Cyprus	16.4	7.6	76.0	15.7	7.6	76.7	17.0	7.7	75.3
Latvia	**30.3**	**9.7**	**60.0**	**27.1**	**8.6**	**64.3**	**32.7**	**10.6**	**56.7**
Lithuania	24.0	6.6	69.4	20.5	5.6	73.9	26.7	7.4	65.9
Luxembourg	17.9	9.2	72.8	17.1	8.0	74.9	18.8	10.5	70.8
Hungary	18.0	7.4	74.6	16.1	6.3	77.6	19.6	8.4	72.0
Malta	9.4	2.5	88.1	8.6	2.2	89.2	10.3	2.8	86.9
Netherlands	25.7	5.5	68.8	22.2	5.1	72.7	29.1	6.0	64.9
Austria	25.2	8.9	65.9	23.8	8.4	67.7	26.4	9.4	64.2
Poland	16.4	7.5	76.0	14.7	7.4	77.8	17.8	7.6	74.6
Portugal	25.0	8.6	66.5	20.7	7.6	71.8	28.7	9.4	61.8
Romania	20.6	5.9	73.5	17.4	4.6	78.1	23.6	7.1	69.3
Slovenia	26.4	9.0	64.6	24.2	8.6	67.3	28.7	9.4	62.0
Slovakia (2)	22.8	9.1	68.1	19.8	8.1	72.1	25.7	10.1	64.3
Finland	26.9	7.3	65.8	23.3	6.7	70.1	30.6	7.9	61.5
Sweden	8.5	4.5	87.0	6.6	3.4	90.0	10.5	5.5	84.0
United Kingdom (2)	14.3	10.9	74.8	12.8	9.7	77.5	15.7	12.0	72.3

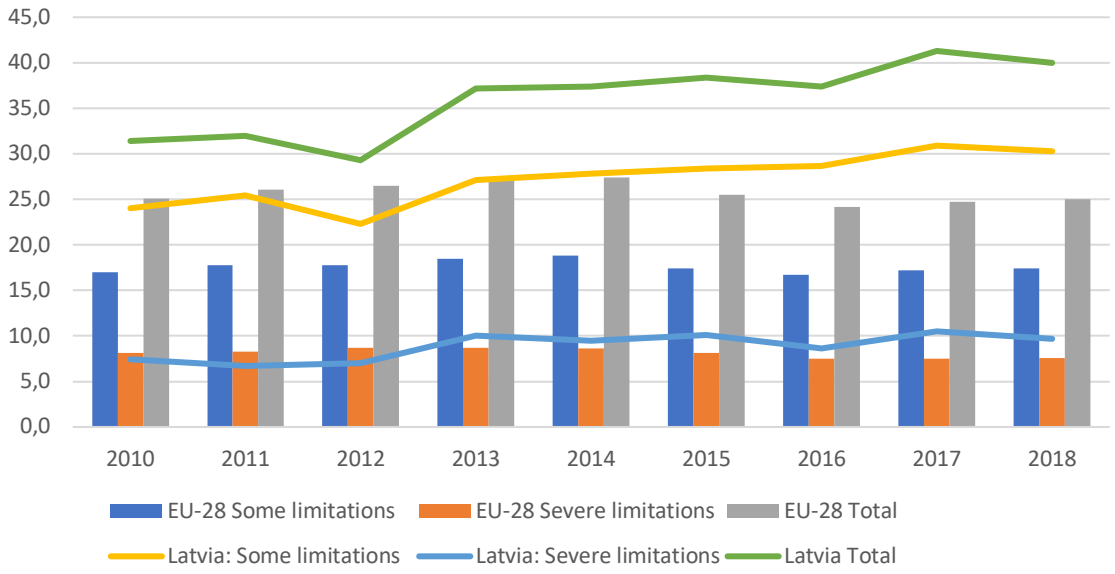
(1) Estimates. (2) 2017 data (3) 2016 data Source Eurostat (online data code hlth_silc_12)

[13] https://ec.EURopa.eu/EURostat/statistics-explained/index.php?title=Functional_and_activity_limitations_statistics

[14] Ibid.

EU SILC is an annual survey conducted since 2003 and as such showcases changes over time in the number of individuals reporting long-standing limitations in usual activities due to health problems. As Figure 1.12 shows, in EU-28, on average, the rates of persons 16 years of age and over experiencing severe and some limitations has remained stable between 2010 and 2018. By contrast, Latvia has experienced increases in both rates and consequently the overall rate increased from 31.4 to 40.0 percent – an increase of 27.0 percent.

Figure 1.12 - Persons 16 years of age and over self-reporting long standing limitations in usual activities due to health problems in Latvia and EU-28 2010-2018



Source: EU-SILC_hlth_silc_20.xls. Eurostat.

Part of this increase might be associated with the aging of the population in Latvia, where between 2009 and 2019 the share of elderly population (older than 65) increased from 18.0 to 20.34 percent, or 13.0 percent and the share of the working age population (15-64 years of age) dropped from 68.0 to 63.4 percent. Given that EU SILC captures persons experiencing "long standing limitations in usual activities due to health problems", other factor could be associated with morbidity patterns among working age population. In that sense, MOW may benefit from an in-depth, cross-sectional analysis of available data on health status of the population to better understand the drivers behind a very high self-reported disability prevalence rate (40.0 percent), once the aging of the population is accounted for.

1.1.3 EHSIS and EU LFS 2011 data

Table 1.2 and Figure 1.13 present results from EU LFS (2011) and EHSIS (2012). On average, in EU-28, based on EU LFS 2011, 14.0 percent of the population was estimated to have basic activity difficulty; at 17.9 percent, Latvia's estimate of population having basic activity difficulty was 28.0 percent higher. Further, 11.0 percent of the population was estimated to have an employment disability. Here, 11.6 percent for Latvia was similar to that in EU-28. Based on EHSIS, the prevalence of disability in EU-28 was estimated at 12.8 percent and for Latvia at 14.6 (14.0 percent higher than the EU-28 average. Thus, Latvia had the 10th highest rate of disability prevalence among EU countries.

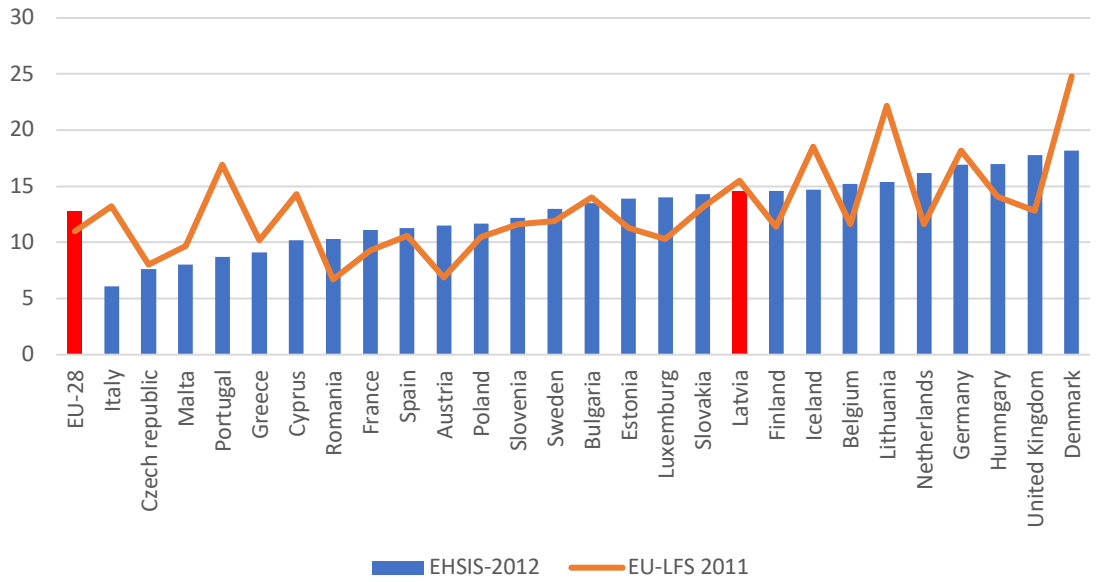
Similar to the EU-SILC results, EHSIS and EU LFS based estimates suggest that women experience higher rates of disability than men and disability increases significantly with age. Disability was inversely related to the education level and labor market activity status.

Table 1.2 -Persons with employment disability and disability in Latvia based on EU LFS 2011 and EHSIS 2012[15]

	People who have a basic activity difficulty, 2011		People who have an employment disability, 2011		People with a disability, 2012	
	Number (thousands)	Prevalence (%)	Number (thousands)	Prevalence (%)	Number (thousands)	Prevalence (%)
EU-28 (')	44 459	14.0	34 778	11.0	*42 228*	*12.8*
Belgium	965	13.9	919	13.2	1 115	15.2
Bulgaria	497	10.2	389	8.0	681	13.5
Czech Republic	604	8.3	698	9.7	549	7.6
Denmark	547	15.1	610	16.9	655	18.2
Germany	6 877	14.9	4 718	10.2	9 091	16.9
Estonia	167	18.5	129	14.3	126	13.9
Ireland	160	5.3	217	7.1	:	:
Greece	459	7.1	436	6.7	657	9.1
Spain	2 343	8.1	2 693	9.3	3 530	11.3
France	8 348	21.1	4 190	10.6	4 432	11.1
Croatia	418	15.3	311	11.4	:	:
Italy	3 164	8.6	2 545	6.9	2 356	6.1
Cyprus	54	9.5	60	10.5	59	10.2
Latvia	248	17.9	160	11.6	197	14.6
Lithuania	268	13.1	243	11.9	307	15.4
Luxembourg	73	21.2	48	14.0	50	14.0
Hungary	883	13.2	757	11.3	1 142	17.0
Malta	21	7.2	30	10.3	23	8.0
Netherlands	1 497	13.6	1 443	13.1	1 832	16.2
Austria	1 328	23.5	878	15.5	653	11.5
Poland	3 665	14.2	2 950	11.4	3 199	11.7
Portugal	1 224	17.2	1 310	18.5	597	8.7
Romania	1 598	10.9	1 693	11.6	1 516	10.3
Slovenia	265	18.6	316	22.2	172	12.2
Slovakia	399	10.3	448	11.6	557	14.3
Finland	761	22.3	620	18.2	511	14.6
Sweden	983	16.1	865	14.1	793	13.0
United Kingdom	6 644	16.7	5 102	12.8	7 430	17.8
Iceland	38	19.2	49	24.8	32	14.7
Norway	:	:	:	:	661	20.1
Switzerland	924	17.4	838	15.8	:	:
Turkey	8 481	17.6	8 155	16.9	:	:

(') People with a disability: EU-27.
Source: Eurostat (online data codes: hlth_dp010, hlth_dp060 and hlth_dpeh005)

Figure 1.13 -Employment disability rates from EHSIS 2012 and EU LFS 2011 (based on Table 1.2)



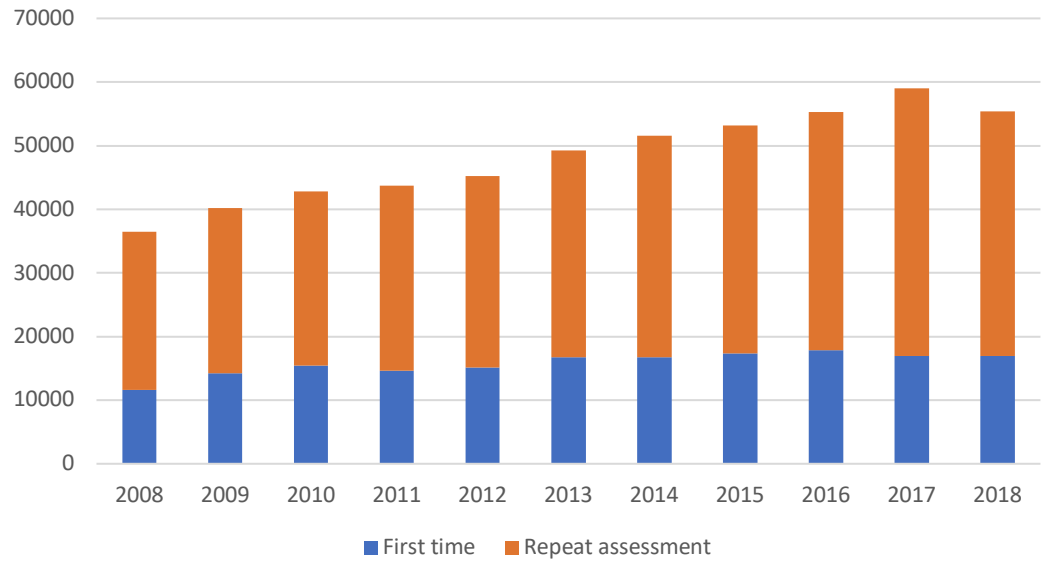
[15] Source: Eurostat: Disability Statistics - Prevalence and Demographics. Statistics Explained. Data extracted in November 2015. Further Eurostat information, Main tables and Database. No planned article updates. https://ec.europa.eu/eurostat/statistics-explained/pdfscache/34409.pdf

1.2 Disability assessment data and trends

In 2018, 66,709 people applied to the SMC to be assessed for disability. Most of these applications, about 70.0 percent, were for disability reassessment. Since 2008, the number of applications has grown steadily. Among applicants, three disease groups dominate: malignant neoplasms, diseases of circulatory system and diseases of musculoskeletal system. Over time (2008-2018), among both first-time applicants and those applying for the reassessment, the shares of very severe disability and moderate disability increased, while the share of severe disability contracted.

There are two streams of persons coming to SMC to be assessed for disability: the first-time assessment and repeated assessment or re-assessment. In 2018, there were 16,949 first-time disability assessments and 38,467 re-assessments. Compared to 2008, the number increased by 32.0 and 35.0 percent, respectively. Overall, reassessment cases dominate -- 70.0 percent in 2018. The trends in the numbers of conducted assessments over 2008-2018 are presented in Figure 1.14

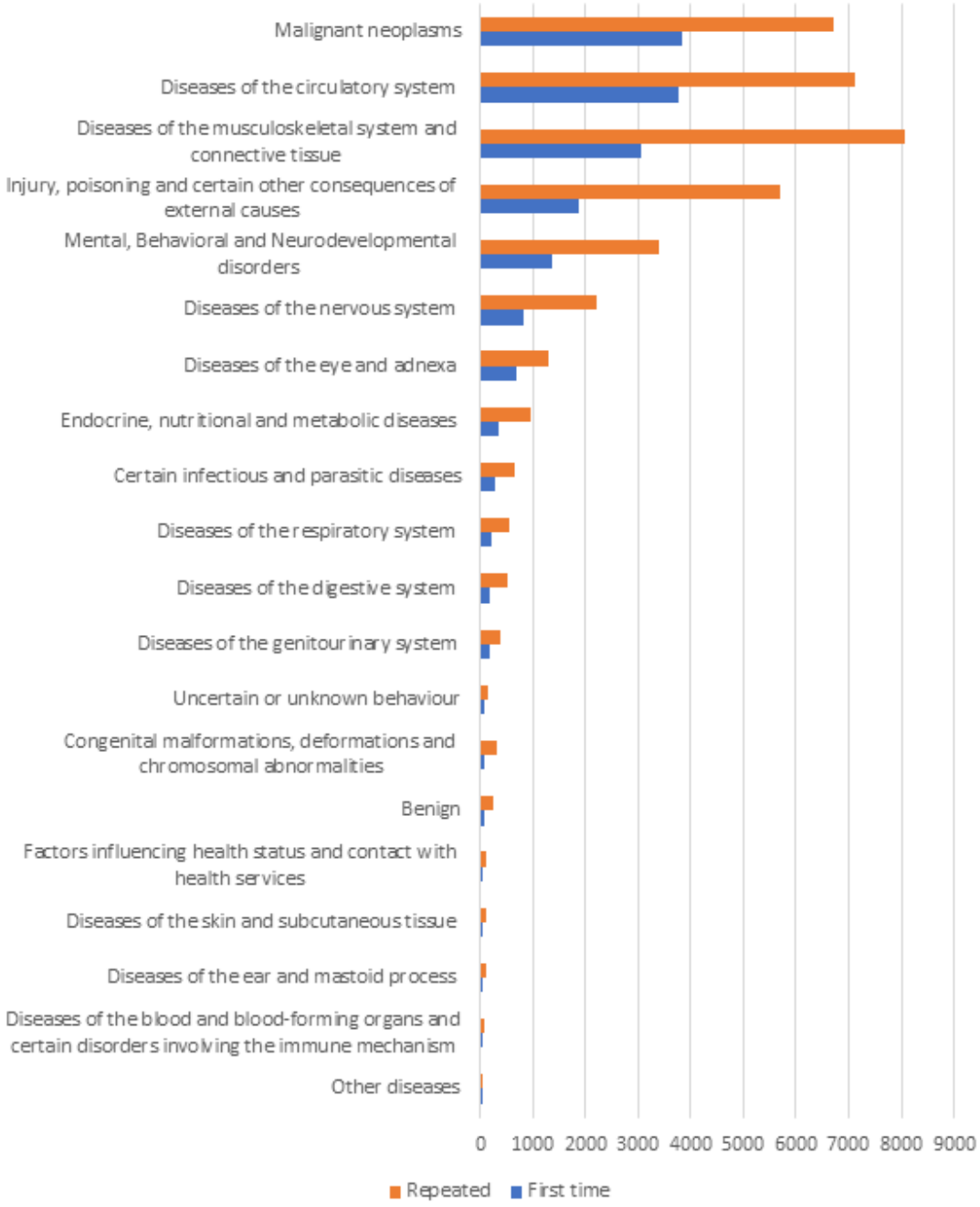
Figure 1.14 -Disability assessments - first time and reassessments 2008-2018



Source: SMC

Three groups of diseases dominated first-time assessments in 2018: malignant neoplasms (23.0 percent), diseases of circulatory system (22.0 percent) and diseases of musculoskeletal system (18.0 percent). Among reassessments, the most common were diseases of musculoskeletal system (21.0 percent), circulatory system (18.0 percent) and malignant neoplasms (17.0 percent) - Figure 1.15.

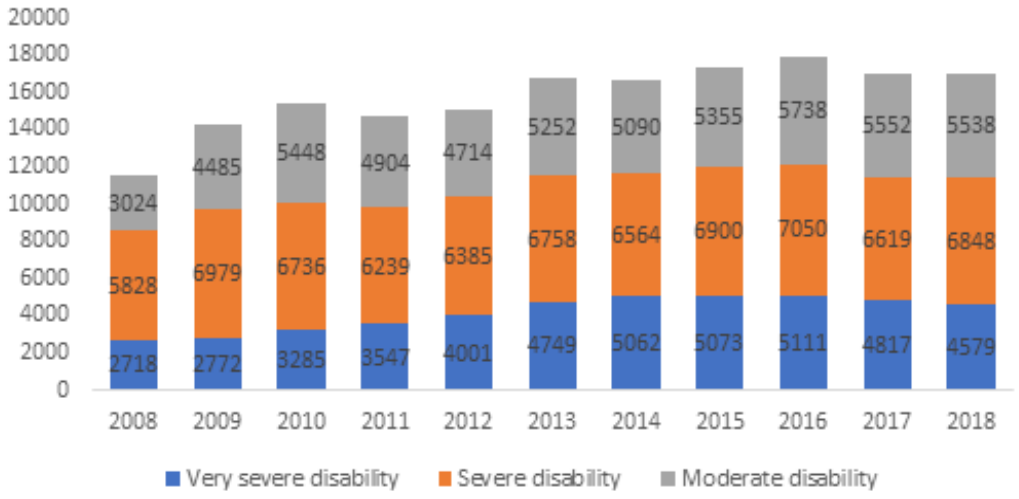
Figure 1.15 -Disability assessments in 2018 by main groups of diseases



Source: SMC.

Figures 1.16 and 1.17 present changes over time (2008-2018) in the SMC decisions by severity of disability for both first-time (Figure 1.16) and repeat assessments (Figure 1.17). In the case of the first-time assessment, the share of very severe disability assessments increased from 24.0 percent in 2008 to 27.0 percent in 2018. The proportion of severe disability assessment of the total decreased from 50.0 to 40.0 percent. Finally, the share of moderate disabilities increased from 26.0 to 33.0 percent.

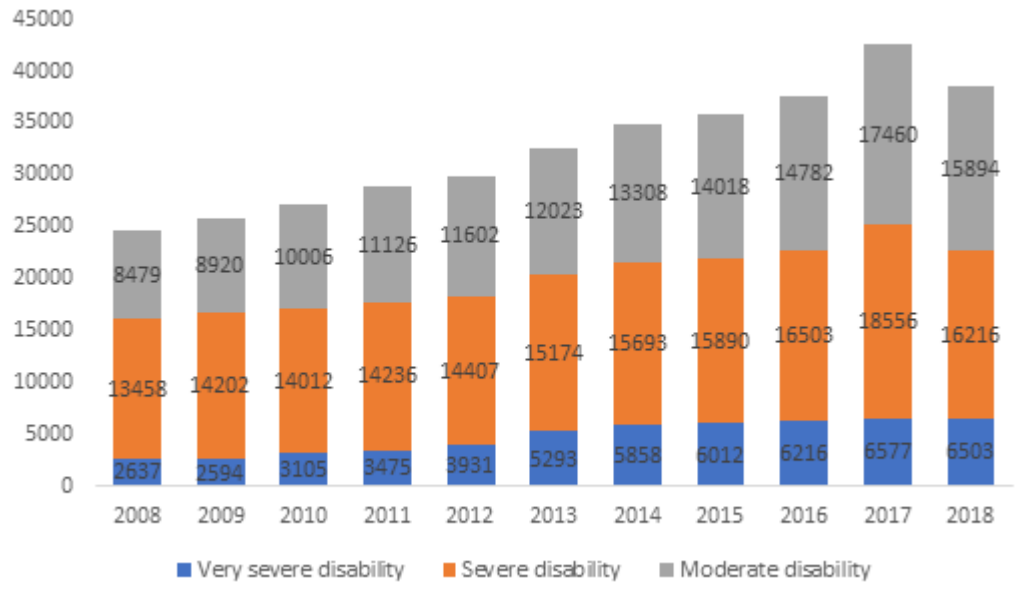
Figure 1.16 -First time disability assessment decisions by severity of disability 2008-2018



Source: SMC

In the case of the repeated assessment, the trend was the same as in the case of the first- time assessment: the share of very severe disabilities increased from 10.7 to 16.8 percent; the share of severe disabilities dropped from 54.8 to 42.0 percent, and the share of moderate disabilities went up from 34.5 to 41.2 percent (Figure 1.17).

Figure 1.17 -Disability assessment decisions in the case of disability reassessment by severity of disability 2008-2018

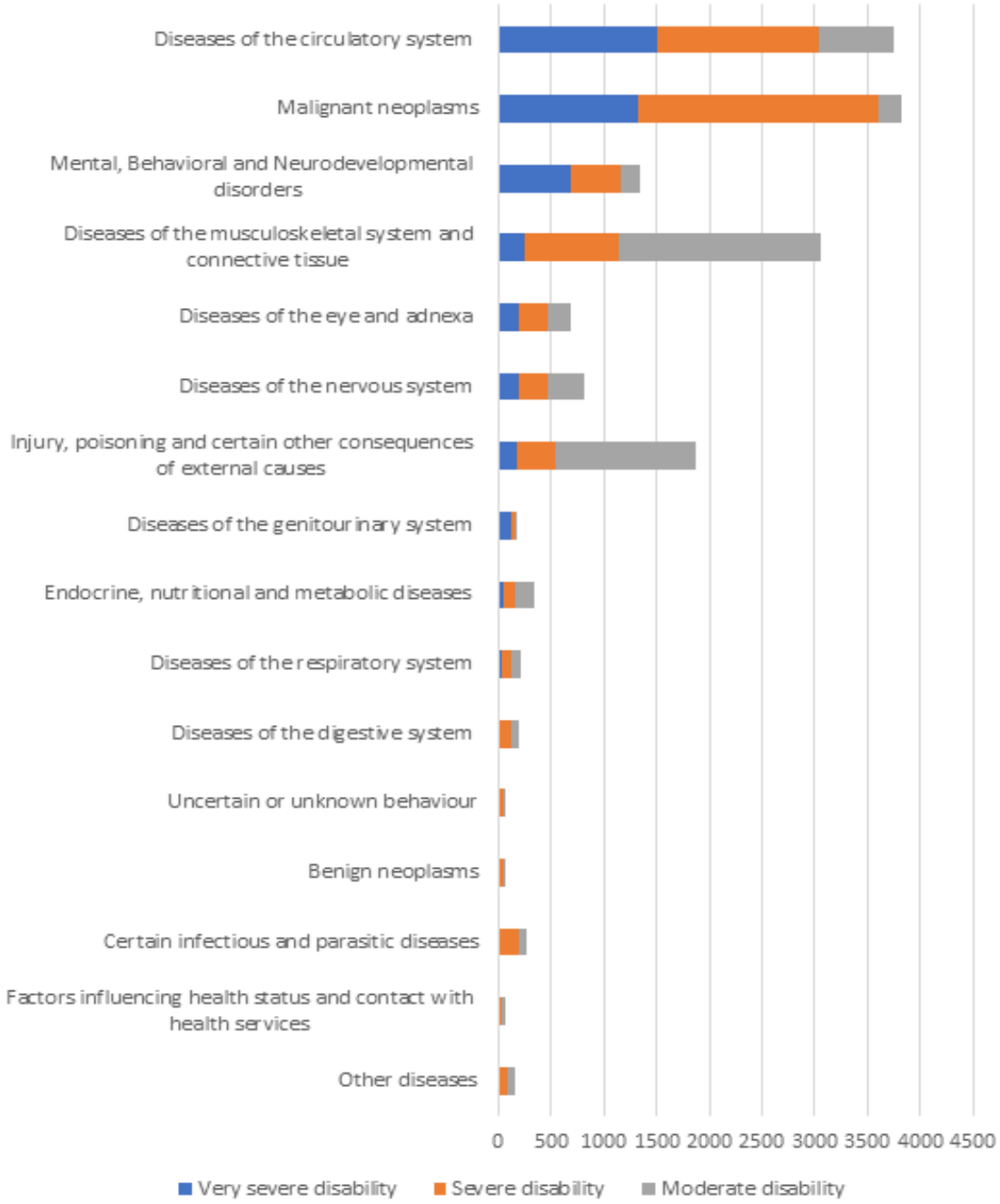


Source: SMC.

In Figures 1.18 and 1.19, we present data on the severity of disability by disease groups and by types of assessment (first-time or reassessment). For very severe disability, the disease pattern is similar in both types of assessment. The most common cause for very severe disability (Group I) are diseases of circulatory system, mostly due to cerebrovascular diseases, malignant neoplasms, such as prostate,

colon, bronchi and breast cancers, and mental, behavioral and neurodevelopmental disorders that include mainly organic, symptomatic and mental disorders.

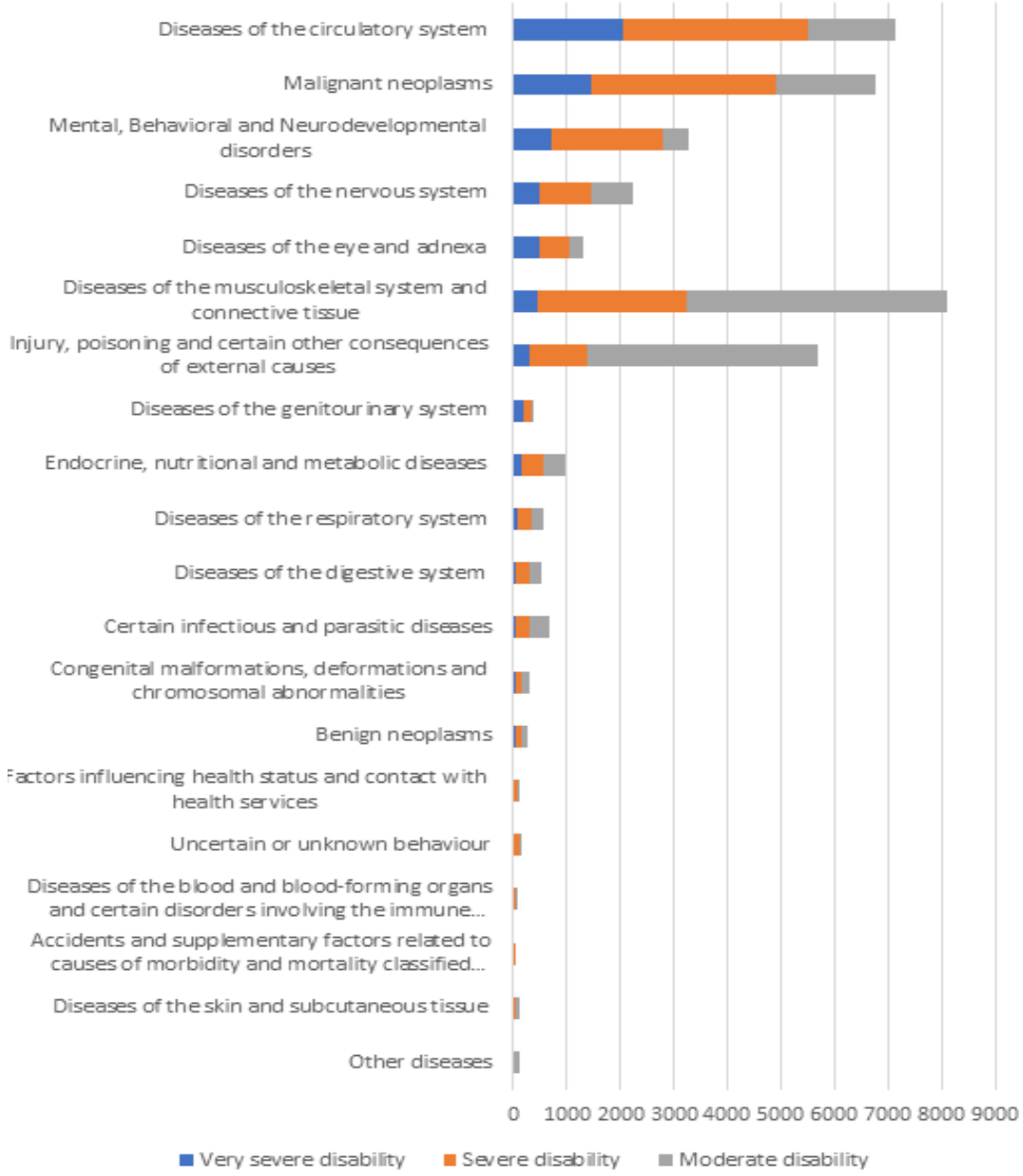
Figure 1.18 -First time disability assessment – severity of disability by main groups of diseases (2018)



Source: SMC.

In the case of severe disability (Group II), the leading health conditions among the first time applicants are malignant neoplasms, diseases of circulatory system, disorders of musculoskeletal system, mainly deforming dorsopathies, spondylopathies and other dorsopathies and injury, poisoning and certain other consequences of external causes, and neurodevelopmental disorders.

Figure 1.19 -Reassessment of disability – severity by main groups of diseases (2018)



Source: SMC.

In the case of the reassessment, the following groups of diseases are the leading cause of severe disability (Group II): diseases of circulatory system, malignant neoplasms, and neurodevelopmental disorders.

Moderate disability group (Group III) consists mostly of persons with disorders of musculoskeletal system mainly deforming dorsopathies, spondylopathies and other dorsopathies and injury, poisoning and certain other consequences of external causes. Data from the 2011 EU LFS shows that 18.4 percent of employed persons in Latvia experienced long-term problems with back and neck. Compared to other EU countries, Latvia ranked in this regard the third, right after Finland and France. Another commonly reported long-term health condition was problems with circulatory system (11.5 percent) - Latvia was ranked second for this condition among the EU-28 countries.

Key findings and recommendations

According to administrative data from SMC , Latvia's prevalence rate of disability was 10.0 percent of the population in 2018, a 50.0 percent increase compared to 2008 (or 5.0 percent on average per annum). EU SILC estimates that in 2018, 40.0 percent of the population experienced long standing limitations in usual activities due to health problems – an increase of 27.0 from 2010 when this estimate was 31.4 percent. More women than men experience disability. Disability is more prevalent among the elderly population and the severity of disability is strongly associated with age. Malignant neoplasms, diseases of circulatory system, musculoskeletal diseases and neurodevelopmental disorders are the most common diseases associated with disability.

A sharply growing increase in disability prevalence can in part be associated with the aging of the Latvian population: between 2009 and 2019 the share of elderly population (older than 65) increased from 18.0 to 20.34 percent, or 13.0 percent and the share of the working age population (15-64 years of age) dropped from 68.0 to 63.4 percent. The share of 65+ is projected to increase to 25.0 percent by 2030 and old-age dependency ratio from 34.5 in 2019 to 46.4 in 2030.[16]

Other socio-economic determinants of health and disability such as health status of the population, morbidity patterns, environmental and other barriers to participation, lifestyle choices and habits, physical activity, access to and quality of health care and support services, income, employment, education, all must have played a role as well. An in-depth empirical study is required to determine the factors that are driving disability rate up in Latvia. It is important to have this information as the UN projects that the Latvian population will decline to 1.48 million by 2050 and that the median age will increase due to low fertility and increasing life expectancy,[17] leading to population ageing. Given that aging is associated with increased rates of disability, disability rates in turn are expected to increase.

As with other countries that will be experiencing the aging of the population, Latvia needs to start preparing for a future in which a significant fraction of the population will be elderly, many of whom will be experiencing disability. Focusing on prevention, and healthy living and aging, and policies to support participation and optimize functioning -- such as remaining in the labor market -- are key to mitigating the social and economic impact of an aging population increasingly experiencing disability.[18]

[16] UN, Department of Economic and Social Affairs Population Division. *World Population Ageing 2019: Highlights*. New York 2019. ST/ESA/SER.A/430.
https://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2019-Highlights.pdf

[17] Latvia's life expectancy at birth in 2018 was: male 70.1 years, female 79.9 and overall 75.2. In 2010, it was 66.5, 77.5 and 72.1 respectively. Latvia ranked 75th among the world countries by life expectancy, well below many other EU countries. Source: UNDP: https://en.wikipedia.org/wiki/List_of_countries_by_life_expectancy

[18] See, for example, WHO. 2015. *World Report on Aging and Health*. Geneva, 2015

2. DISABILITY POLICY AND SYSTEM: LEGAL FRAMEWORK

In this section we present key legal acts setting up disability policies and system in Latvia. Given the emphasis of the report on the disability assessment system, we focus on acts that cover the determination of disability and loss of ability to work, and support to people with disabilities for their successful inclusion in society (namely, health care, education, social security, and social care and employment services). *The purpose of this chapter is not to analyze legal provisions or to compare Latvia to other countries. Its purpose is to describe the current legal framework of disability policies and programs*. The list of laws and regulatory and administrative acts issued by the Cabinet of Ministers (hereafter "the Cabinet") and other government agencies is presented in Annex 3 to this Report.

Photo credit: MOW

2.1 United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)

Latvia is a party to the *UNCRPD*[19] (signed July 18, 2008; ratified March 1, 2010[20]). By signing and ratifying the Convention, Latvia is legally committed "… to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity".[21] During the process of the Convention's ratification, Latvian laws and other regulatory acts were adjusted to align with the provisions of the Convention.

UN CRPD Preamble … Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others…

Article 1: The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.[22]

2.2 The Constitution

The highest law in Latvia, the *Constitution of the Republic of Latvia*[23] does not refer specifically to "disability" or "a person with disability". The only time the word disability is mentioned (Article 110) is in the context of the state support to disabled children.

*Article 110. […] The State shall provide special support to **disabled children**, children left without parental care or who have suffered from violence.*

The Constitution focuses on ensuring and protecting the Fundamental Human Rights of all Latvian citizens. Chapter VIII[24] of the Constitution on *Fundamental Human Rights* prohibits any discrimination (Article 91); stipulates that the right to life of everyone shall be protected by the law (Article 93); establishes that everyone has the right to social security in old age, incapacity for work, unemployment and other cases specified by Law (Article 109), to education (Article 112), the right to freely choose employment and workplace according to the personal abilities and qualifications (Article 106) and guarantees the right of everyone to address state or local government institutions and to receive a reply (Article 104). The Constitution affirms that "the State shall protect human health and guarantee basic level of medical assistance for everyone" (Article 111).[25] Article 112 sets that primary

[19] Convention on the Rights of Persons with Disabilities. United Nations. 2006. https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf
[20] On the entry into force of the Convention, 2010. Information of the Ministry of Foreign Affairs No. 41/174-1047. Riga: Ministry of Foreign Affairs. Available at: https://likumi.lv/ta/id/206558-par-konvencijas-speka-stasanos
[21] UNCRPD, *Ibid*.
[22] *Ibid*.
[23] The Constitution of the Republic of Latvia: https://likumi.lv/ta/id/57980-latvijas-republikas-satversme
[24] *Ibid*.
[25] *Ibid*.

education in Latvia shall be compulsory and that the State shall ensure that everyone is entitled to free primary and secondary education.

2.3 The Disability Law

The Disability Law[26] is the most important law in the field of disability. The purpose of the law is to prevent or reduce the risk of disability for persons with predictable disability and to reduce the consequences of disability for persons with disabilities. It defines disability, sets up an organization of disability assessment and provides for support measures to reduce disability, disability risk and the consequences of disability.

The Disability Law differentiates between: ***Predictable disability***: a restriction of functioning caused by illness or injury, which, in the event that the necessary medical treatment and rehabilitation services are not provided, may be a reason for determining disability; and ***Disability***: a long-term or permanent restriction of a very severe, severe or moderate degree of functioning, which affects a person's mental or physical abilities, ability to work, self-care and inclusion in society.

The criteria, terms and procedures for the determination of predictable disability, disability and incapacity for work are regulated by the Cabinet.

The Disability Law also regulates the organization of the assessment of predictable disability and disability. It designates "SMC to conduct these assessments. The physicians (expert assessors) of the SMC independently assess limitations in functioning. The criteria, time periods and procedures determining predictable disability, disability and incapacity to work are defined by the Cabinet regulations.[27] Details on disability assessment, including legal provisions are discussed in Chapter 3 of this Report.

Chapter 4 of *The Disability Law* regulates support measures to reduce predictable disability, disability risk and the consequences of disability:

(i) For a person with a predictable disability, the risk of disability is prevented or reduced by implementing the measures specified in the individual rehabilitation plan and ensuring the right to receive priority medical services paid from the state budget, social rehabilitation services, vocational rehabilitation services and vocational suitability services, and implementing other support measures as set up by relevant Cabinet regulations.

(ii) For a person with disability, the consequences of disability should be reduced by implementing measures laid out in the individual rehabilitation plan[28] and by providing support measures, including assistant services, the service of a sign language interpreter, technical aids, assistance adapting one dwelling for persons with a Group I disability and the right of persons with Group I or II disability, a child with disability and a person accompanying a person with Group I disability or a child with disability to use, free of charge, all types of public transport on the territory of Latvia (excluding air transport, taxi and passenger transport by inland waters).[29]

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[26] Disability Law (adopted on May 5, 2010, effective January 1, 2011) https://likumi.lv/ta/id/211494-invaliditates-likums

[27] Regulations Regarding the Criteria, Time Periods and Procedures Determining Predictable Disability, Disability, and the Loss of Ability to Work, 2014. SI 2014/805. Riga: Cabinet of Ministers: https://likumi.lv/ta/id/271253-noteikumi-par-prognozejamas-invaliditates-invaliditates-un-darbspeju-zaudejuma-noteiksanas-kriterijiem-terminiem-un-kartibu

[28] Regulations on Individual Rehabilitation Plan for a Person with a Predictable Disability and a Person with Disability, 2011. SI 2011/9. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/224135-noteikumi-par-individualo-rehabilitacijas-planu-personai-ar-prognozejamu-invaliditati-un-personai-ar-invaliditati

[29] Detailed information regarding support for people with disabilities is provided in Chapter Four of this Report.

2.4 The Law on Social Security

This Law[12] establishes the principles of developing and operating a social security system, the main social rights and obligations of individuals and basic conditions for their realization, as well as types of social services, including social and educational assistance, promoting social justice and social security. The purpose of this Law "is to ensure that social services are provided in a timely manner and that the institutions responsible for the provision of services are easily accessible".[30] Persons with disabilities are not singled out as a special group to be protected, except for the prohibition of discrimination (Article 2(1); s. 2(1), the right to social insurance in case of disability (s. 5), the right to treatment and rehabilitation measures in association with disability (s. 29) and the involvement of persons with disabilities in social life (s. 12).

Article 2 (1); Section 2 (1): In providing social services, different treatment is prohibited depending on a person's race, ethnicity, skin color, gender, age, disability, health status, religious, political or other beliefs, national or social origin, property or family status or other circumstances.[31]

Chapter II of this Law is dedicated to social rights (articles 4-12): support for education and employment; social insurance; the right to health care; social guarantees in the event of loss of health due to special circumstances; reimbursement of family expenses up to a certain amount; allowance for the provision of a suitable apartment; help for children and young people; social assistance and Involvement of disabled people in public life.

Chapter III, Article 12. Involvement of Disabled Persons in Social Life: "Disabled people, regardless of the cause of their disability and persons with long-term or permanent health loss, are entitled to assistance: 1) … related to the involvement of these persons in the life of the society, creating suitable working conditions for them in accordance with their working abilities and interests; 2) to improve their state of health, prevent the deterioration of the state of health and reduce the degree of loss of health and ability to work."[32]

Chapter III regulates social services and defines social services: "social services are measures which are provided by the state or local governments in the form of money, benefits in kind or services in order to promote the full implementation of a person's social rights."[33]

2.5 The Law on State Pensions and the Law on State Social Allowances

The right of persons with disabilities to receive a disability pension is regulated by the Law on State Pensions.[34] The Law on State Social Allowances[35] regulates social benefits provided by the state. Persons living on the territory of Latvia covered by the state mandatory pension insurance scheme are entitled to old-age, disability and survivors' pension. The amount of the disability pension depends on the length of insurance and social insurance contributions, and is calculated according to a formula, taking into account the assessed severity of the disability. More detailed information is provided in Chapter 4. The Law on State Social Allowances sets the types of state social benefits in cash, eligibility

[30] *Ibid*. Article 1(2).
[31] *Ibid*.
[32] *Ibid*.
[33] *Ibid*.
[34] On State Pensions 1995: https://likumi.lv/ta/id/38048-par-valsts-pensijam
[35] Law on State Social Allowances 2002: https://likumi.lv/ta/id/68483-valsts-socialo-pabalstu-likums

conditions, procedures for granting and disbursement of allowances, and grievance and redress procedures. The amount of benefits is determined by the Cabinet. This Law provides for the following disability specific benefits: an allowance for the compensation of transport expenses for disabled persons who have difficulty moving; an allowance for care of a child with disability; and a benefit for a disabled person who needs care. Persons with disabilities are entitled to other state social allowances under this Law, provided that they meet required eligibility conditions. More detailed information is provided in Chapter 4 of this Report.

2.6 The Law on the Protection of Children's Rights[36]

Chapter VIII of this law, A Child with Special Needs (in Latvian "bērns ar īpašām vajadzībām") defines a child with special needs.

Section 53. "A child with special needs is a child who due to a disorder of the organ system caused by an illness, injury or congenital defect, needs additional medical, pedagogical and social assistance, regardless of whether a disability has been established in accordance with the procedures prescribed by law."[37]

It also stipulates the right of children with special needs to live a full life, the right to special care, as well as the preparation of pedagogical and social workers for work with children with special needs.

2.7 Legal provisions related to education

Education in Latvia is regulated by the *Law on Education,*[38] the *General Education Law,*[39] the *Vocational Education Law*[40] and the *Law on Higher Education Institutions,*[41] as well as regulations of the Cabinet of Ministers issued on the basis of these laws.

The right to education for children with disabilities is encompassed by the term "special education", which according to the Explanatory Notes to the *Law on Education* means "general and professional education adapted for persons with special needs and health problems, or with special needs or health problems". When implementing special education programs, the state of health of the student should be taken into account.

Chapter VIII of *The General Education Law* regulates special education. It stipulates that "special education programs should provide learners with acquired or congenital functioning disorders the opportunity to acquire general education in accordance with their special needs."[42] The law refers to learners with special needs as including learners with mental disabilities, learners with intellectual disabilities, learners with visual and hearing impairments, deaf learners, learners with learning disabilities or severe language disorders, students with physical development disorders, mental health disorders or somatic diseases. It would be useful to adopt a consistent terminology when referring to children with special educational need.

[36] Law on the Protection of the Children's Rights 1998. https://likumi.lv/ta/id/49096-bernu-tiesibu-aizsardzibas-likums
[37] *Ibid*.
[38] The Law on Education, 1998. https://likumi.lv/ta/id/50759-izglitibas-likums.
[39] The General Education Law 1999. https://likumi.lv/ta/id/20243-visparejas-izglitibas-likums
[40] The Vocational Education Law 1999. https://likumi.lv/ta/id/20244-profesionalas-izglitibas-likums.
[41] The Law on Higher Education Institutions 1995. https://likumi.lv/ta/id/37967-augstskolu-likums
[42] Ibid, s. 49 (1).

The law stipulates that the State Pedagogical-Medical Commissions (SPMC) (see: Annex 4 to this Report) determine the most appropriate educational program for children with special needs. Learners with special needs may attend general education classes, special education classes or groups in education institutions or special education institutions. The duration of education depends on the condition of the child's health and type and severity of disability. The law stipulates that learners with special needs may be enrolled in general education programs. The requirements for general education institutions to admit students with special needs are determined by the Cabinet. The schools should ensure that appropriate support measures are provided to learners with special needs. The school should develop an individual educational plan for each enrolled learner with special needs.

The procedures by which children are enrolled in general education programs, special education institutions and special preschool education groups are determined by the Cabinet.[43] Children with special educational needs are admitted to the special education program based on the opinion of the SPMC. This opinion is one of the most important documents for a child with special needs to receive appropriate education. The opinion critically depends on the child's state of health for which parents need to submit valid medical documentation (issued not later than six months before the commission meeting). Essentially, the ability of a child to learn is determined based on the medical diagnosis.

The *Law on Higher Education Institutions* does not have special provisions for students with special needs. The *Professional Education Law* makes a reference to students with special needs only to stipulate that the cost of vocational education for students with special needs will be covered by the state budget if they attend special education institutions.[44]

2.8 Legal provisions related to health care

The key law regulating access to health care in Latvia is the *Medical Treatment Law* of 1997.[45] This law mentions disability twice. In Section 3, the Law stipulates that the health care of persons with predictable disability is a priority. In Section 71, it regulates the SMC -- that conducts health and work ability assessments and determines disability.

The organization and payment of health care for persons with a predictable disability is regulated by the Cabinet under Regulation No. 555.[46] Although Regulation No. 555 was issued under the *Medical Treatment Law*, persons with a predictable disability are not identified as a priority group for receiving health services. The Regulation only stipulates that for persons with Group I disability and children with disabilities a family doctor's home visit is covered from the state budget.

The *Health Care Financing Law*[47] provides that persons with a Group I disability are exempt from the patient co-payment (EUR 1.42 for family doctor, EUR 4.27 for specialist). As of 2021 it is expected that this exemption will also apply to persons with Group II disability. Persons with a predictable disability are not mentioned in this Law.

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[43] "Procedures by which learners with special needs are enrolled in general education programs, special educational institutions and special preschool education groups and discharged from them, as well as transitioned into the next Grade". 2015. SI 2015/591. Cabinet of Ministers. Available at: https://likumi.lv/ta/id/277597-kartiba-kada-izglitojamie-tiek-uznemti-visparejas-izglitibas-iestades-un-specialajas-pirmsskolas-izglitibas-grupas-un-atskaitit.

[44] The Vocational Education Law 1999. (s.31 (4) 1): https://likumi.lv/ta/id/20244-profesionalas-izglitibas-likums.

[45] The Medical Treatment Law 1997: https://likumi.lv/ta/id/44108-arstniecibas-likums.

[46] "Procedures for the Organization and Payment of Health Services", 2018. SI 2018/555. Riga: Cabinet of Ministers. https://likumi.lv/ta/id/301399-veselibas-aprupes-pakalpojumu-organizesanas-un-samaksas-kartiba.

[47] The Health Care Financing Law, 2018. s.6.(2) p.15, p.16): https://likumi.lv/ta/id/296188-veselibas-aprupes-finansesanas-likums

To manage more effectively waiting time to access services, priority groups are identified. They mostly comprise patients with certain diagnosis (e.g. cancer, diabetes, psychological and behavioral disorders.), as well as children and pregnant women. People with a predictable disability may receive separate health services; these services must be specified in the individual rehabilitation plan approved by the SMC.[48]

Section 63. A medical treatment institution shall start providing scheduled state paid healthcare services ***to a person with a predictable disability*** *[...] within the following time limits: outpatient health services and scheduled ambulatory and hospital medical rehabilitation services within 15 working days; scheduled operations - within a period of five months.*

Priority access is also determined for medical rehabilitation services. This service is, for example, granted to persons with acute and subacute functioning difficulties in the areas of communication, cognitive capacity, movement, self-care, instrumental daily activities, as well as persons with subacute functioning difficulties limiting their capacity to work and is likely to cause a disability. It is also granted to children under three years of age with a high risk of developing a functioning disorder, children aged between three and six years with moderate and severe functioning restrictions and rescue workers who have been injured in the discharge of their duty.

To cover the health services funding gap, the Regulation No. 555 stipulates that for persons who are sick for a long time, persons with a predictable disability and persons on ventilators, the resources should be planned based on the spending in the previous year and the planned state budget for the current year. Likewise, the co-pay reimbursement for persons exempted from paying it, the budget should be planned based on the spending in the previous year and attributing it proportionally to the total number of patients.[49]

Latvia has been looking for solutions to introduce compulsory health insurance. The process has been slow. The planned changes envisaged that persons with Groups I and II disability would be entitled to the "full" basket of services, while persons with Group III disability would only be entitled to these services, only if covered by the scheme.

2.9 The Law on Social Services and Social Assistance

Social services, their coverage and eligibility criteria and matters related to financing and payment of social care, social rehabilitation and vocational rehabilitation services is determined by the *Law on Social Services and Social Assistance.*[50] The Law stipulates that social services should be provided only on the basis of an assessment of individual needs and resources of a person conducted by a social work professional. The services should be provided at the person's place of residence or as close to it as possible. Only if such level of services is insufficient, social care and social rehabilitation should be provided in a long-term care and social rehabilitation institution. The Law establishes a general requirement that a person is obliged to pay for social care and social rehabilitation services she/he receives. It also provides a list of services which are financed from the state budget resources. To receive technical aids a lump-sum contribution or co-payment is defined. More detailed information on services is provided in Chapter Four.

[48] Regulation No. 555.
[49] *Ibid*.
[50] The Law on Social Services and Social Assistance 2002. https://likumi.lv/ta/id/68488-socialo-pakalpojumu-un-socialas-palidzibas-likums

2.10 Labor market regulations

In this area, the most important laws are *The Labor Law,*[51] *The Law on Support for Unemployed Persons and Persons Seeking Employment*[52] and *The Social Enterprise Law*[53] and the accompanying Cabinet Regulations.

The Labor Law stipulates that legal employment relationship is binding for all employers (regardless of their legal status) and employees, and that this legal relationship between employers and employees is established on the basis of a contract of employment. The term "disability" is indicated eleven times:

- section 7 of the Law prohibits discrimination - the right to work, fair, safe and healthy working conditions, as well as fair remuneration shall be ensured without any direct or indirect discrimination regardless of the person's [...] disability;
- the Law determines the employer's obligation to adjust the work environment, if such measures do not impose a disproportionate burden on the employer;

Section 7 (3). In order to promote the introduction of the principle of equal rights in relation to persons with disabilities, an employer has an obligation to take measures that are necessary in conformity with the circumstances to adjust the work environment, to facilitate the possibility of persons with disabilities to establish employment relationships, perform work duties, be promoted to higher positions or be sent to occupational training or further education, insofar as such measures do not place an unreasonable burden on the employer.

- the Law prohibits different treatment depending on the disability of the employee;
- in cases when firms reduce the number of employees, the Law provides some protective measures for workers with children up to 14 years of age or a child with disability up to the age of 18 years, employees with disabilities or radiation sickness, provided that performance and qualifications of the employees do not differ significantly;
- the Law prohibits an employer from terminating an employment contract with an employee who has been certified as disabled, or during the employee's temporary incapacity for work due to an accident at work or occupational disease;
- employees who have a child with disability up to age of 18 years have the right to request and get an approval to work part time, they can use their paid annual leave at any time during the year convenient to them and have the right to three paid supplementary days of leave.

All other provisions of the Labor Law apply to disabled persons in the same way as to any other employer or employee.

A similar principle of mainstreaming is enshrined in the *Law on Support for Unemployed Persons and Persons Seeking Employment Law.*

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[51] The Labor Law 2001. https://likumi.lv/ta/id/26019-darba-likums

[52] The Law on Support for Unemployed Persons and Persons Seeking Employment 2002. https://likumi.lv/ta/id/62539-bezdarbnieku-un-darba-mekletaju-atbalsta-likums

[53] The Social Enterprise Law 2017. Available at: https://likumi.lv/ta/id/294484-sociala-uznemuma-likums

Persons with disabilities are included in the list of active employment measures - measures for specified groups of persons, [...] for persons with a determined disability. The Law stipulates that "a person with a determined (certified) disability shall also be considered to be able to work…".

All other provisions of the Law (e.g. the right to acquire the status of an unemployed person or a job seeker, to participate in active employment and preventive measures to reduce unemployment, rights and duties of the unemployed person and the job seeker for persons with disabilities) are the same as for any other person.

The State Civil Service Law[54] which regulates civil service in Latvia does not mention persons with disabilities.

A relatively new law in the field of employment of people with disabilities is *The Social Enterprise Law*[55] aimed at facilitating the improvement in the quality of life and foster employment of population groups at risk of social exclusion. The Law creates an economic activity environment favorable for social enterprises. A more detailed information on support for unemployed persons with disabilities is provided in Chapter Five.

Key findings and recommendations

As noted, the purpose of this chapter is to *describe* the current legal framework concerning disability policies and programs, not to analyze it or compare Latvia to other countries. However, several observations can be made.

Following the signing of the CRPD, Latvia undertook significant efforts to include the provisions of the Convention into its laws and regulations prior to ratifying the Convention in 2010. Since then, the laws have been continuously adjusted to help Latvia implement the Convention.

The most important law establishing the framework for disability policies and programs is *The Disability Law*. Many other laws contain provisions specific to disabled people as well.

In general, following the principles of mainstreaming, equal treatment and non-discrimination, in most relevant legal acts, persons with disabilities are not singled out as a specific group: persons with disabilities have equal rights as everyone else. At the same time, where appropriate, persons with disabilities are entitled to disability specific benefit and services.

The terminology used when referring to children and persons with disabilities varies. It would bring much clarity to develop a glossary of terms pertaining to persons with disabilities to guide policymakers and practitioners.

[54] The State Civil Service Law 2000. https://likumi.lv/ta/id/10944-valsts-civildienesta-likums
[55] The Social Enterprise Law 2017. https://likumi.lv/ta/id/294484-sociala-uznemuma-likums

3. DISABILITY ASSESSMENT SYSTEM

In this chapter, we discuss the disability assessment system in Latvia, including disability assessment criteria and administrative processes to implement them.

Photo Credit: MOW

On January 1, 2015 Latvia introduced changes to its disability assessment system. The new approach, in addition to the health status of an individual, also looks at her/ his functioning in several life domains – mobility, communication, self-care and participation in society (see also Annex 5 to this Report). These changes reflect efforts to introduce the WHO ICF[56] view of disability into disability assessment in Latvia. The WHO ICF's is a bio-psycho-social or interactional view of disability. It is the dominant one today: disability is viewed as not solely about how a person's body functions, since two people can have exactly the same impairment while one experiences a severe disability and the other little or no disability because they live in very different contexts that make very different demands on them. On the other hand, disability is not just about these environmentally or socially created disadvantages, because the body and how it functions makes a difference as well[57] (see Annex 1 to this Report).

[56] *Ibid.* See Box 3.1, as well.

[57] Bickenbach J., Posarac A., Cieza A., Kostanjsek N., Assessing Disability in Working Age Population, A Paradigm Shift: from Impairment and Functional Limitation to the Disability Approach, 2015, World Bank. Washington D.C. Available at:

3.1 Legal framework

Disability assessment includes the assessment about the kind and extent of disability a person has, i.e. it includes the specific disability assessment criteria and specific processes how the disability assessment is carried out and decision on disability is made.[58]

Disability assessment in Latvia is regulated by two key legal acts: *The Disability Law*[59] and the *Regulations Regarding the Criteria, Time Periods and Procedures Determining Predictable Disability, Disability, and the Loss of Ability to Work*[60] (subsequently referred to as Cabinet Regulation No. 805). The *Disability Law* provides a general disability system and policies framework. The *Disability Law* differentiates between predictable disability and disability (see Chapter Two). The *Disability Law* is operationalized in the Cabinet Regulation no. 805, which, as its title indicates, regulates in great detail criteria for disability assessment and administrative procedures to implement them.

The Law classifies disability in the following way:

(i) Children: disability is determined without division into groups. For children the assessment is based on the existence of a specific medical condition which has been diagnosed by a treating doctor who has provided documentation to confirm the diagnosis.

(ii) Adults (until 31 December 2014): Depending on the degree of restriction of physical or mental abilities:

(a) disability group I - very severe disability,
(b) disability group II - severe disability,
(c) disability group III - moderate disability;

(iii) Working age adults (from 1 January 2015): 18 years of age until mandatory retirement age (currently – 2020: 63 years and 9 months)[61]: Depending on the restriction of functioning, its degree and the percentage loss of ability to work:

(a) disability group I, if the loss of capacity for work is between 80 and 100 per cent - very severe disability,
(b) disability Group II, if the incapacity for work is between 60 and 79 per cent - severe disability,
(c) for disability group III, if the loss of capacity for work is between 25 and 59 per cent, moderate disability.

The Cabinet Regulation No. 805 specifies that the assessment of disability or working capacity should be performed for a person with a physical or mental health disorder due to which s/he has been continuously treated for at least six months before the date of submission of the application to SMC. The assessment may be conducted earlier, if the health disorders are severe and with an unfavorable prognosis or the functioning limitations have become stable. A person who has been assessed for

https://openknowledge.worldbank.org/bitstream/handle/10986/22353/Disability0Ass00Report0June01802015.pdf. See Annex 1 to this Report for the summary of the study.

[58] *Ibid*.

[59] The Disability Law (adopted on May 5, 2010, effective January 1, 2011) https://likumi.lv/ta/id/211494-invaliditates-likums

[60] The Regulations Regarding Criteria, Time Periods and Procedures Determining Predictable Disability, Disability, and the Loss of Ability to Work, 2014. SI 2014/805. Riga: Cabinet of Ministers: https://likumi.lv/ta/id/271253-noteikumi-par-prognozejamas-invaliditates-invaliditates-un-darbspeju-zaudejuma-noteiksanas-kriterijiem-terminiem-un-kartibu

[61] The retirement age in Latvia is gradually increasing until it reaches 65 years in 2025. The increase schedule is as follows: 2019: 63 years and 6 months; 2020: 63 years and 9 months; 2021: 64 years; 2022: 64 years and 3 months; 2023: 64 years and 6 months; 2024: 64 years and 9 months; and 2025: 65 years.

disability/ work capacity has the right to request a reassessment at any time if her/his state of health has significantly deteriorated and the resulting functioning impairment is considered stable.[62]

(iv) For elderly citizens, after they have reached the age required for a state old-age pension (63 years and 6 months in 2019, 65 years of age from 2025 onwards), depending on the restriction of functioning and its degree: disability group I - very severe disability; disability group II - severe disability; and disability group III - moderate disability. For persons who have reached mandatory retirement age, when performing repeated disability assessment, the person's disability status is retained even if the limited functioning, in accordance with which disability was determined, is related to objective age-related changes in the body determined prior to attaining retirement age.[63]

The *Disability Law* also regulates the organization of the assessment of predictable disability and disability. It designates the SMC to conduct these assessments. The physicians of the SMC (referred to in this Report as "expert-assessors") are medical professionals and are independent in conducting the assessment.

According to the *Disability Law* and Regulation No. 450[64] a document certifying disability is a *disability certificate*. The certificate is issued or sent to the applicants by registered mail within five working days after the SMC has decided on disability.

3.2 Disability assessment criteria and administrative process

In 2018, almost 67,000 persons applied to SMC for disability assessment: of which 30.0 percent for the first-time assessment and 70.0 percent for reassessment. SMC certified as disabled 56,383 adults or almost 85.0 percent of those who applied. Most, 38,467 or 68.0 percent, were reassessments. There were 17,833 adults (or 32.0 percent of the total) certified as disabled for the first time. The cases of predictable disability were only few (26 cases). The absolute numbers and shares have remained stable since 2016 (Table 3.1).

Table 3.1 -Adults certified as disabled 2016-2019 (first semester)

	2016	2017	2018	2019
Applied for the assessment	69,900	68489	66,709	70271
Granted disability - total	55,352 (100%)	59,038 (100%)	56,383 (100%)	26,871 (Jan to June) (100%)
Newly granted disability (adults)	17,883 (32.3%)	16,975 (28.6%)	17,883 (31.7%)	7,728 (28.8%)
Repeatedly granted disability (adults)	37,394 (67.7%)	42,000 (71.4%)	38,467 (68.3%)	19,117 (71.2%)
Granted predictable disability (adults)	75 (0.0%)	63 (0.0%)	33 (0.0%)	26 (0.0%)
Granted/Applied in %	79.2	86.2	84.5	n/a

Source: Welfare Information System, actual data on 09.10.2019

Data in Table 3.1 indicate insignificant interest in predictable disability. There is no empirical data to explain why this may be the case. Interviews conducted for the purpose of this study suggest that one

[62] The Cabinet Regulation No. 805.
[63] *Ibid*. (s.6): https://likumi.lv/doc.php?id=211494
[64] The Regulations Regarding the Document Specimen Certifying Disability, the Procedures for the Issuance and Record-keeping of the Document, 2012. SI 2012/450. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/249985-noteikumi-par-invaliditati-apliecinosa-dokumenta-paraugu-dokumenta-izsniegsanas-un-uzskaites-kartibu

of the key factors could be that few benefits are provided to persons assessed with predictable disability, as well as difficulties in obtaining this assessment. The *Disability Law* in Chapter IV, section 12 stipulates that "For a person with predictable disability the risk of disability shall be prevented by ensuring his or her priority to receive medical treatment, as well as social and professional rehabilitation services paid from the State budget in accordance with the individual rehabilitation plan"[65]. Due to scarce financial and human resources in health care and rehabilitation, the waiting time for state paid services is long and discourages potential applicants from applying.

The concept of predictable disability is a good one. However, given a very low interest in it, the MOW should review it and rethink its concept: it should either abolish it (not a recommended option) or give it a much higher prominence in its efforts to optimize functioning of persons experiencing disability, including ensuring that assistance and rehabilitation services are provided to maximize their functioning and participation in society, including in the labor market (a recommended option). Given unfavorable demographic trends noted in Chapter One, Latvia should emphasize efforts to maximize functioning and labor force participation.

In Latvia, the disability assessment process is initiated with a medical referral to SMC (see Annex 6 to this Report for a detailed description of the steps in disability assessment). As noted above, employed persons are referred to SMC by a general practitioner/ treating doctor after 26 weeks of a paid sick leave have lapsed because (i) the necessity of the extension of the sick leave is deemed needed; (ii) for the assessment of predictable disability; or (iii) for determination of disability or work capacity.[66]

The disability assessment process follows the following steps (see also Figure 3.2):

- ***Referral***: For disability assessment process to be initiated, a General Practitioner (GP) or an applicant's treating doctor fills in a Medical Report (Form u-088).
- ***Application to SMC for disability assessment*. T**he Medical Report is submitted by the person seeking assessment. If the person has limited legal capacity, her/his trustee can submit the application. In the case of *predictable disability*, the application should be accompanied by an individual rehabilitation plan, prepared by the applicant's family physician in collaboration with a physical medicine and rehabilitation physician. As for the applicant's functioning limitations, the plan should define appropriate long- and short-term goals and include description of intended treatment, medical, social and vocational rehabilitation measures and deadlines for their implementation. In the case of *disability and work capacity assessment*, the application should be accompanied by a Medical Report issued by a GP/ treating doctor and a self-assessment of functioning abilities (for applicants 18 years and above) completed by the applicant.
- ***Case registration***: The SMC Client Service employee registers the application in the SMC Disability Information System (DIS), reviews submitted documents and (i) requests applicant to submit missing documents, if any, or (ii) initiates a disability assessment case, if documents are in order. Initiated case is transferred to a SMC officer who evaluates the application and assigns the case to an expert assessor.
- ***Case review and assignment of an assessor:*** The SMC officer reviews the case and based on the medical diagnosis and other provided information, designates the assessment expert (assessor) who will perform the assessment. The case is transferred to a designated expert assessor.
- ***Case assessment***: The designated SMC expert assessor reviews the case documents and prepares an assessment report. She/he may also obtain additional information from the E-Health Information System or DIS. At this stage the options are as follows: (i) if information is sufficient

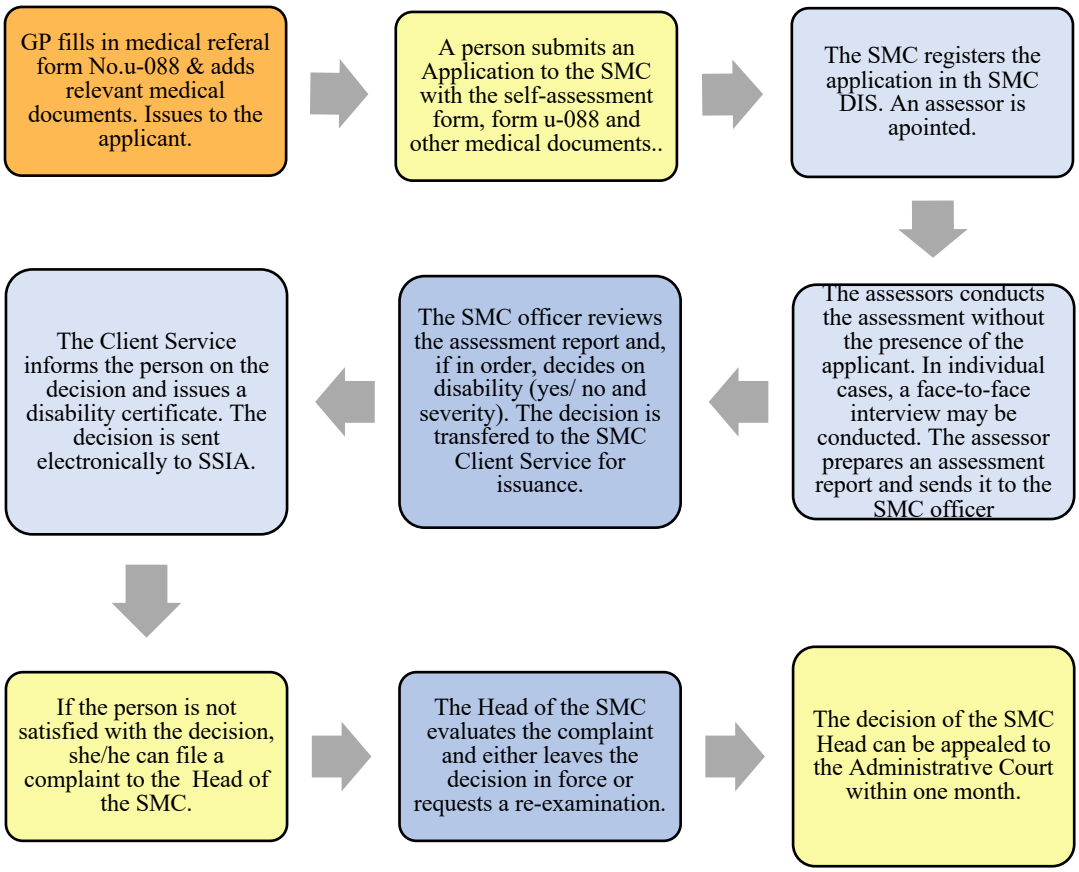
[65] *Ibid.*

[66] After 26 weeks of a paid sick leave, if the incapacity for work continues, the treating doctor is obliged to refer a person to SMC. SMC may extend or deny the extension or decide to determine predictable disability or disability instead of the extension.

and the case is clear, the SMC expert assessor reviews the case and prepares the assessment report; (ii) if the case is not clear, the expert assessor informs the SMC Client Service about the need to perform a face–to–face assessment. In this case, the Client Service communicates with the applicant and schedules an appointment. The assessment is conducted through a face-to-face interview; (iii) if the case is complicated or there is a need for additional information (other diagnostic or treatment results, or other assessments), the expert assessor requests additional information from the applicant.

- ***Case assessment report***: After having done the review and assessment, the case designated SMC expert assessor fills in the assessment report and submits it to a SMC official. This report includes information about the applicant's health conditions, functioning difficulties and other relevant information.

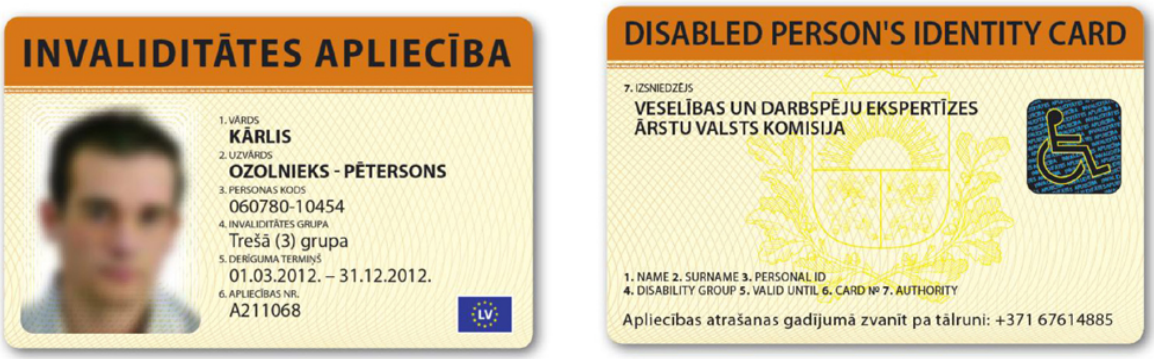
Figure 3.1 Disability assessment processes



- ***Case assessment report review***: The SMC official reviews the case assessment report and approves the document, if in order. If there is lacking information or some other issues, s/he sends the report back to the expert assessor for amendments or corrections.
- ***Decision***: If the case assessment report is in order, the SMC official approves it, decides on the severity of disability and prepares a decision document. At the same time, based on the severity of disability and functioning limitations, a document containing an opinion for additional specific benefits and services might be provided to the applicant. Three such opinions could be provided: on special care, on transport benefit and on assistant service, but only if there are specific medical indications provided by a GP/treating doctor. A person may be given all three opinions, one or two, or none, based on the assessment. The decision with the proposed services and benefits is transferred to the Client Service to formally issue a disability certificate (i.e. disability decision) and the Disabled Person's Identity Card and inform the applicant about the issuance. The Decision

is issued in the word format document (an official administrative document). Disabled person's identity card is issued in the smart card format. The person receives both.

Figure 3.2 - A specimen of the disability card in Latvia



Source: Annex 1 to the Cabinet Regulation No. 450.

- ***Disability decision issuance***: The certificate is delivered to the applicant in her/ his preferred way (electronically, by registered mail or in person at the SMC office).

The information about disability and the disability assessment process is available on the web pages of several government agencies (see also Annex 7 to this Report). The most comprehensive information (in Latvian and Russian) is presented on the SMC web page (www.vdeavk.gov.lv). It includes:

- A description of the disability assessment process, explanation of changes since 2015, and references to relevant legal documents;
- A special section dedicated to General Practitioners – describing the process and documents that should be submitted for both predicted disability and disability assessments;
- A special section dedicated to the implementation of the changes to the assessment process – the application of the functioning self-assessment questionnaire, the assessment process, and grievance redress procedures.
- Information about benefits/ services a person with disabilities can access, eligibility requirements and how to make an application.
- Information and hyperlinks to available e-services that are provided in the joint State Service Portal www.latvija.lv

For details, see Annex 5 to this Report.

3.3 Initiating the process: medical referral to the SMC and self-assessment

A Medical Report "A Referral to the State Medical Commission for the Assessment of Health Condition and Working Ability" (Form u-088) is the first step in the disability assessment process.[67] This form is filled in by a GP or the patient's treating doctor. The Form and the instructions on how to fill it in are available on the SMC web site.[68] It is also contained in the Annex No. 30 to the Cabinet Regulation No. 265 "Procedures for Keeping Medical Documents".[69] The instructions provide recommendations on

[67] "Procedures for Keeping Medical Documents", 2006. SI 2006/265. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/132359-medicinisko-dokumentu-lietvedibas-kartiba.
[68] http://www.vdeavk.gov.lv/informacija-par-procesu-pie-gimenes-arsta/
[69] "Ministru Kabinets. 04.04.2006. Noteikumi Nr.265 "Medicīnisko dokumentu lietvedības kārtība". https://likumi.lv/ta/id/132359-medicinisko-dokumentu-lietvedibas-kartiba

how to prepare a Referral to SMC with a short description of the information that should be provided in each section of the Referral Report.

A hyperlink[70] to the "Manual on Criteria for the Assessment of Health Disorders" is also provided[71]. The Manual contains information on functioning disorders according to the ICF and medical diagnoses related to diseases following the WHO International Classification of Diseases – 10th issue (ICD-10) codes. The content of this manual is organized in 18 groups of medical fields, such as dermatology, gastroenterology, neurology, cardiology. For each, diagnoses, according to the ICD-10 are listed in the table, along with lists of related impairments of functions according to the ICF and with examinations that would justify the diagnosis. In the part "Impairments of functions according to ICF", mostly codes of the ICF "Body functions" second level classification are listed. There are also some diagnoses with more specific codes. Under some of the diagnoses, codes for "Body structures" are listed. Activity and participation categories are included only under diagnoses of neurology, in non-specified way (d110-d999) and under traumatology (categories related to mobility).

The Form u-088 contains the following information:

- Healthcare institution (code and name) where the Form is filled in;
- Applicant's name, surname, personal ID number, gender;
- Diagnoses: primary, secondary, etc., diagnoses with ICD codes;
- Detailed description of the applicant's medical condition, including treatment history and its outcomes, and expected treatment and prognosis, if possible;
- Results of diagnostic procedures and conclusions;
- Applicant's sick leave history in the previous 6 months, related to the primary disease and the total period of sick leave during the last 3 years;
- Information on physical and psychiatric examinations, assessment of impairment of body functions and activity limitations (the description can be written in the form or added as separate documents);
- Reason for preparing the Medical Report, marking one or several from the following: predictable disability assessment; disability and work capacity assessment; an assessment for special care; an assessment for the reimbursement of cost of purchasing/ adapting transportation vehicle and reimbursement of travel expenses for medical examination; an assessment for services of an assistant, and other reasons.
- Date, and name and surname and signature of the specialist who has issued the Medical Report;
- List of additional attached documents.

The Medical Report is completed as a free-flowing form – it contains boxes that have to be filled in manually. This requires not only that a GP can describe minutely the state of pertinent body functions and structures of a person, but also that s/he is very well versed in ICD and ICF to be able to provide information that would objectively describe the state of health and functioning of the patient. The forthcoming ICD-11 has integrated ICD and ICF and would allow for a standardized and automated selection of ICD and related ICF codes.[72] In addition, ICD-11 also includes the WHO Disability Assessment Schedule (WHODAS), a psychometric tool to assesses the lived experience of disability in terms of ICF domains. Using WHODAS would greatly improve the collection of objective information

[70] http://www.vdeavk.gov.lv/wpcontent/uploads/2014/10/Ieteikumi_Nosutijuma_aizpildisanai.doc

[71] http://www.vdeavk.gov.lv/wp-content/uploads/2014/11/2013_Rokasgramatas_1_pielikums_Krit%C4%93riji.doc

[72] See, for example, Selb M, Kohler F, Robinson Nicol MM, Riberto M, Stucki G, Kennedy C, Üstün B. *ICD-11: a comprehensive picture of health, an update on the ICD-ICF joint use initiative*. J Rehabil Med. 2015 Jan;47(1):2-8. doi: 10.2340/16501977-1928. PMID: 25650017.

on the state of health and functioning of a person and would greatly facilitate disability assessment. But the rolling out and mainstreaming of ICD-11 will take several years at least.

The Medical Report is valid for two months after the date of its issuance. The Medical Report can only be prepared as a Word document, which is later printed out and signed. It could also be signed electronically and saved as an electronic document. After the Medical Report has been issued to the applicant, she/he fills in the questionnaire about functioning abilities (self-assessment) and can then submit the application to SMC for the assessment.

As is, the Medical Report and other supporting medical documents are compiled into a paper file and submitted to SMC as such. This creates many issues when the applicant has been treated by several medical practitioners or has frequently been on a sick leave. Latvia introduced an E-Health system in 2018 that allows for all individual medical records, including the episodes of sick leave, to be recorded and stored. But the system is yet to be fully implemented. As a result, the disability assessment referral remains predominantly manual, and paper based, even in cases when the Medical Report is available in electronic form (there is no data in how many cases the medical report is available electronically).

The E-Health system provides an opportunity to move from manual to automatic processing of the Medical Report and its submission to SMC. Form u-088 should be available in the E-Health system. Provided that patient's medical records are stored properly in the E-Health system, much of the medical information needed for the Form u-088 should be pulled automatically, including the patient's sick leave record. Moreover, by means of an automated exchange of information with the civil registry records, once the patient's personal ID number is entered into the Form u-088, information such as his name, marital status, date of birth and address, etc., could be populated automatically. Likewise, social security records, including employment status could be included as well. Data about the medical establishment and GP/treating doctor filling in the referral would be populated automatically too. The information requested from GP/ treating doctor should be standardized and well structured, matching the assessment criteria, enabling them to focus on providing detailed description of the patient's health and functioning status. Once completed, the Medical Report should be electronically signed, saved in the pdf format and transferred to SMC. The patient could be informed by an SMS or an email message that the referral was submitted to SMC. She/he should be able to register with the DIS to be able to view the Form, but also to be able to fill in the functioning self-assessment questionnaire and the application to be assessed electronically. In this way, most of the document processing would become automatic. The advantages of using electronic processing as a standard are many: from better privacy protection and securing data accuracy to saving time of GPs and patients to faster and more efficient case processing.

MOW plans to introduce electronic filing of disability assessment referrals, but the plans are yet to be implemented. Ultimately, the success would depend on the systematic implementation of the E-Health system, which would make the needed information available and easily accessible in the electronic format.

Self-assessment of functioning limitations. To apply for disability assessment, along with the Medical Report (Form u-088), adult applicants are required to fill in a questionnaire about difficulties they experience in their life related to their health condition (for a sample of questions, see Table 3.2). The self-assessment form must be completed by the applicant, or when not possible, by the applicant's trustee, a social worker or a treating doctor.

The self-assessment form is provided in the Annex 1 to the Cabinet Regulation No 805. Annex consists of the questionnaire and short, question by question methodological instructions for completing it.

There is also an instructional booklet (available on-line)[73] and a YouTube tutorial,[74] to help the applicants answer questions. It is not clear how many applicants use these resources. The form is publicly available at GP offices and on the website of the SMC.[75] The form can be printed or saved on a computer.

Table 3.2 -The self-assessment questionnaire – an excerpt pertaining to the domain of functioning "understanding and communication"

.	Action to be taken	Degree of difficulty				
		no difficulty	slight difficulty	moderate difficulty	great difficulty	very great difficulty
Understanding and communication						
1.	Concentrate on some work for 10 minutes					
2.	Remembering to do something important					
3.	Analysis of everyday problems and their solution					
4.	Learning a new task, such as getting to a previously unknown place					
5.	Understanding what others say					
6.	Communication with strangers					
7.	Understanding with people close to you					
8.	Conversation and conversation maintenance					

Source: Annex 1 to The Regulations Regarding the Document Specimen Certifying Disability, the Procedures for the Issuance and Record-keeping of the Document, 2012. SI 2012/450. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/249985-noteikumi-par-invaliditati-apliecinosa-dokumenta-paraugu-dokumenta-izsniegsanas-un-uzskaites-kartibu

The self-assessment consists of two parts. The first part includes information about the person.[76] If the person has worked for less than three years or is currently not working, the person must also indicate what kind of work s/he has performed during the last three years and for how long. The second part includes 19 questions in four domains of human functioning: understanding and communication (8 questions, see Table 3.2); mobility (5 questions); self-care (4 questions) and home life and work (2 questions). The answer modalities pertain to the degree of difficulty and are: "no difficulty"; "slight difficulty"; "moderate difficulty", "great difficulty" and "very great difficulty". There is also a blank space where the applicant can add comments, where person can indicate the problem and its description regarding any of activities. At the beginning of the questionnaire, the person is reminded that "The questionnaire contains questions about activities that you may have difficulty

[73] The brochure with detailed information about the self-evaluation form, as well as instructions on how to answer the questions:
http://www.vdeavk.gov.lv/wp-content/uploads/2014/11/Noverte_A5buklets_viegls.pdf/

[74] The YouTube tutorial can be viewed at: https://www.youtube.com/watch?v=L0s_S5q0sLY&feature=youtu.be/

[75] The State Medical Commission for the Assessment of Health Condition and Working Ability; http://www.vdeavk.gov.lv/ekspertizei-nepieciesamie-dokumenti/. The questionnaire is available in Latvian, Russian and English: http://www.vdeavk.gov.lv/iesniegums-un-funkcionalo-speju-pasvertejuma-anketa/. Other material is available in Latvian only.

[76] Name, surname, personal code, telephone number, education, place of work and profession.

with, in relation to your physical and mental health. Answer these questions by considering how difficult these steps for you are. Choose one answer and mark it with an x in the appropriate box".[77]

The 19 questions are similar to questions contained in the WHO Disability Assessment Schedule (WHODAS: the 36-question version).[78] However, some are phrased a bit differently. Choosing some domains or some questions is not a proper application of WHODAS, which can only be applied in its entirety to maintain its validity, and so will not validly provide a full picture of disability in terms of ICF view of disability. In any case, the self-assessment questionnaire is not scored, and it so plays only a minor role in disability assessment, if at all. The absence of objective scoring means that there is no reliability to the evaluation and may be subject to subjective bias.

The self-assessment form also provides short guidance question by question on how to answer questions. For example, question 11 ("Moving around inside your home", is explained as "movement in room or between rooms, including use of technical aids"). The person is instructed to consider if the performance of the relevant activity requires major effort or it causes a discomfort or pain, the speed of performing the activity, and if the way the activity is performed has changed. The self-assessment should only indicate difficulties associated with the health status.

There is no information whether and to what extent the results of self-assessment have any impact on the decision on the disability status. Anecdotal evidence suggests that the impact is marginal.

Individual rehabilitation plan (hereafter - IRP) must be submitted along with the application, if a predictable disability assessment is applied for. The Plan must be prepared by a GP or treating doctor and should include:

- History of medical and rehabilitation interventions in chronological order;
- Planned interventions;
- Justification for the need of further medical rehabilitation;
- Duration and deadlines for treatment and medical rehabilitation;
- Expected results.

Regarding functioning, the IRP should include:

- Limitations in functioning concerning the body parts and body structures;
- Limitations in functioning with regard to the level of activities and participation;
- Environmental and personal factors that impact activities and participation.
- IRP short- and long-term goals.

Medical indications for special care: an assessment of ability to carry out everyday activities: For special care benefits, a questionnaire on ability to carry out everyday activities and the living environment of the person must be obtained. This questionnaire is filled in by a social worker of the local government social service office or an occupational therapist. The questionnaire is provided in the Annex 2 to the Government Regulation No. 805: "The questionnaire for a person's daily activities and environmental assessment".[79] The questionnaire contains five sections: personal information; assessment of living conditions and environment, Barthel Index[80] questions and scoring points for self-

[77] *Ibid.* Annex 1.
[78] See: WHO, WHODAS, available at: https://www.who.int/classifications/icf/whodasii/en/
[79] *Ibid.* Annex 2.
[80] The **Barthel Scale/Index (BI)** is an ordinal scale used to measure performance in activities of daily living (ADL). Ten variables describing ADL and mobility are scored, a higher number reflecting greater ability to function independently following hospital discharge. Time taken and physical assistance required to perform each item are used in

care, mobility and home activities,[81] duties in household maintenance (e.g. cooking, cleaning, laundry, shopping) and other (e.g. driving, hobbies). Examples of questions are provided in Table 3.3.

Figure 3.3 -Examples of questions included in "The questionnaire for a person's daily activities and environmental assessment"

6. Self-care, mobility and home activities	
6.1. Eating	**Points**
☐ unable to perform this operation on its own	**0**
☐ need help	**1**
☐ independent	**2**
Comments	
6.2. Getting around (from bed to chair and back)	**Points**
☐ sitting unable to maintain balance	**0**
☐ when moving requires a lot of physical help, can sit	**1**
☐ little physical or verbal assistance is required when moving	**2**
☐ independent	**3**
Comments	

…

7. Duties in household maintenance
7.1. Cooking
☐ prepared completely independently
☐ independently, but with difficulty
☐ Need help
☐ food cannot be cooked
Comments

Source: Annex to the Cabinet Regulation No. 805.

3.4 Application to SMC, case registration, review and assignment of an expert assessor

Once a person has been issued a medical referral, has filled in a self-assessment functioning questionnaire, and has obtained other needed documents,[82] she/he must formally apply[83] to SMC to

determining the assigned value of each item. The Barthel Index measures the degree of assistance required by an individual on 10 items of mobility and self-care ADL. https://www.physio-pedia.com/Barthel_Index

[81] For the assessment of self-care, mobility and activities related to home life, a Barthel index is used. The Cabinet of Ministers Regulation no. 279 " Regulations on the Procedures by which Persons Receive Social Rehabilitation Services in Social Rehabilitation Institutions and Requirements for Providers of Social Rehabilitation Services": https://likumi.lv/ta/id/190188-noteikumi-par-kartibu-kada-personas-sanem-socialas-rehabilitacijas-pakalpojumus-socialas-rehabilitacijas-institucijas-un-prasib...

[82] Additional documents can be also submitted if the person or the treatment doctor consider them necessary for the assessment (e.g. extracts from medical institutions, analyses and test results, consultancy findings).

[83] "Application to the State Medical Commission for the Assessment of Health Condition and Working Ability": http://www.vdeavk.gov.lv/ekspertizei-nepieciesamie-dokumenti/.

be assessed for predictable disability, disability and loss of work ability, extension of the sick leave, eligibility for some services. In the Application Form, the applicant must provide personal data,[84] the type of assessment she/he is applying for, and should list all submitted documents, including the form u-088, self-assessment questionnaire, a personal photograph/ digital image, etc. She/he should also indicate the preferred way to receive disability certificate (in person, through an authorized person, by post to the specified address or by post to another address). The applicant should fill in the application date and sign the application. If the application is submitted on someone's behalf, then the authorized person includes additional information about her/him: personal data and in which capacity s/he represents the applicant (parent of the child, guardian or a notarized power of attorney).

Documents may be submitted in person; by post; in the form of an electronic document (according to the legislative enactments on execution of electronic documents); or using e-service in the joint State Service portal www.latvija.lv.[85]

If the application is submitted using the e-service, the application is submitted and sent automatically to DIS. However, there are difficulties in using the e-service: (i) The application cannot be submitted unless the applicant indicates the SMC location for a personal interview. The assessment does not require a personal interview any longer, but the software has not been adjusted. (ii) There are language barriers for applicants not understanding Latvian. While the portal provides the option to choose the language (Latvian, Russian and English), only some fields are displayed in other languages; the most functionality is available only in Latvian.

Table 3.3 -Application submitted to SMC by the mode of application

Applications submitted/ year	Total	using e-service	Personally/ by post	e-service use in %
2016	69,900	341	69,559	0.49%
2017	68,489	338	68,151	0.49%
2018	66,709	526	66,183	0.79%
2019	70271	668	69603	0.95%

Source: SMC, actual data on 07.10.2019

Overall, according to statistics from SMC (Table 3.4), very few applications are submitted through the e-service. Looking forward, direct application through the Joint State Service Portal www.latvija.lv should be a norm, with all other supporting documents being pulled out from the E-Health and other government systems. Likewise, as long as it is required, the self-assessment form should be filled in and submitted online. This would allow for a much higher accuracy of answers, as the applicants can be guided with pictures and descriptions to help them answer the questions. They should also be able to fill in the questionnaire over several sessions prior to the final completion and submission.

As noted above, upon the submission of the application, the SMC Client Service registers the application, a SMC officer reviews it and assigns an assessor to the case.

[84] Name, surname, personal code, citizenship, address, telephone number and email address.
[85] Joint State and Local government portal; https://www.latvija.lv/en.

SMC should conduct the assessment and decide within one month[86] from the day of the application submission.

3.5 Case assessment and case assessment report

Disability assessment in Latvia relies heavily and depends crucially on information provided by a GP or a treating doctor who assesses the patient's health disorders and functioning limitations and reports on them in the Medical Report (Form u-088) to SMC. It is based on trust that a GP or treating doctor has provided an accurate and complete account of the applicant's health and functioning status. The assessment is paper based and no face to face interaction is required during the assessment. More often than not, medical reports are filled in by hand, which on its own can create difficulties, because not everyone's writing is legible. In case of very severe disability (Group I disability) where a person is being assessed for care needs, the SMC requests information from the social worker of the local government social service office or an occupational therapist about everyday activities and environment of the person.

Based on all case information, a designated SMC expert assessor conducts the assessment of the applicant's health and functioning status and records the results in an assessment report, with conclusions and recommendations. This report is transferred to an official of the SMC for a review and a decision on the disability severity and group and an opinion on care needs in cases when Group I disability is determined. Essentially, the assessment compares the information in the case file with the assessment criteria from the Cabinet Regulation No. 805.

The assessment is specifically guided by criteria established in annexes 3-6 of the Cabinet Regulation No. 805.

3.5.1 Predictable disability

For predictable disability: Annex 3 to the Cabinet Regulation No. 805 provides *criteria for the assessment of predictable disability*. According to it, predictable disability is determined if all the following criteria are met:

1. Transient incapacity for work and/or continuous treatment for 26 weeks, as evidenced by documents issued by the attending physician.
2. The person has significant functioning limitations caused by an illness or an injury that are not yet considered to be sufficiently stable and constant over the next six months.
3. The draft individual rehabilitation plan prepared by the attending physician that indicates: treatment and rehabilitation measures performed in chronological order; planned treatment measures; justification for the need for further medical rehabilitation; periods and terms of treatment and medical rehabilitation; expected results of treatment and rehabilitation measures.

The assigned expert assessor reviews the documents and prepares an assessment report, which describes the applicant's health disorders and functioning restrictions, measures provided and to be provided in the individual rehabilitation plan, and the expected outcomes. The report with conclusions is uploaded into the DIS of SMC for further processing.

An official of the SMC reviews the assessment report and following the above-mentioned Annex 3 ("Criteria for Assessment of Predictable Disability") decides to determine predictable disability and its duration. S/he also approves the individual rehabilitation plan for the applicant. The official may

[86] In certain cases, when additional information is needed or in very complicated cases, this period can last up to four months.

decide not to follow the conclusions/recommendations from the assessment report, but there is no information available about the circumstances in which this may happen.

3.5.2 Disability in children

For disability in children: Criteria for assessing disability in children are provided in the Annex 4 to the Cabinet Regulation No. 805: "*Criteria for determining disability and providing an opinion on the need for special care for persons under 18 years of age"*. Annex 4 comprises two parts: Part One – Criteria for determining disability, and Part Two - Criteria for providing an opinion on the necessity of special care.

Criteria for determining disability provide names of diseases and pathological conditions and related description of clinical and functioning status condition for 12 groups of diseases: diseases of the nervous system, mental and behavioral disorders, ear and parotid gland diseases, diseases of the eyes and visual accessory organs, diseases of the internal organs, surgical diseases, endocrine, nutrition and metabolic diseases, skin diseases, oncological diseases, blood and blood-forming organs diseases and immune system disorders, congenital malformations, deformities, metabolic diseases and chromosomal abnormalities and combined pathology. For example, if a child has epilepsy, disability is determined if a child has great epileptic seizures at least six times a year or frequent small epileptic seizures (several times a week). See Table 3.5 as an illustration.

Table 3.4 -Criteria for determining disability in children
(an excerpt from the criteria table)

Names of diseases and pathological conditions	Description of clinical and functional status
1. Diseases of the nervous system	
1.1. Consequences of congenital, acquired or inherited diseases and disorders of the nervous system	Moderate or severe movement disorders in the form of paresis, paralysis, hyperkinesis, movement coordination, language disorders, persistent, marked sensors vegetative disorders
1.2. Neuromuscular synapses and muscle diseases	Decreased muscle strength and strength, resulting in moderate or severe movement and posture disorders
1.3. Epilepsy	Major seizures at least six times a year or frequent minor attacks (several times a week)
Note. Sections 1.1, 1.2 of this chapter. and 1.3. the diagnosis referred to in paragraph has been evaluated and substantiated by a certified neurologist	

Source: Annex 4 to the Cabinet Regulation No. 805.

Part Two of Annex 4 provides 24 criteria for the opinion on the necessity of special care. Those criteria are based on names of diseases and pathological conditions. For example, child with diagnosis F – 73 Profound mental retardation has a right to special care, if diagnosis is confirmed by the certified child psychiatrist or child has a malignant tumor with very severe functioning impairments, if diagnosis is confirmed at the Children's Clinical University Hospital Oncology Department.

Consequently, for children, the assessment is based on the existence of a specific medical condition which has been diagnosed by a treating doctor who has provided documentation to confirm the diagnosis. In case of some illnesses (diagnoses), a disabled child has a right to benefit from "special care".

3.5.3 Disability and work capacity in adults

For disability and work capacity in adults: The assessment of disability and loss of ability to work is conducted for a person with physical or mental health disorders, due to which s/he has undergone

continuous medical treatment for at least six months (has been on a sick leave for more than 26 weeks) prior to the day of conducting the assessment, or s/he has suffered from a stable functioning disorders, as confirmed by medical documents. (Disability and loss of ability to work assessment may be conducted earlier, if the person has severe health disorders whose prognosis is unfavorable or is suffering from stable functioning disorders.) Annex 5 to the Cabinet Regulation No. 805 "Criteria for assessing health disorders and functional abilities" provides criteria for disability/work ability assessment. It includes two tables: I. Health disorders assessment table and II. Functioning ability evaluation table.

The Health Disorders Assessment Table is short, and we replicate it in full below:

Table 3.5 -Health disorders assessment table (full)

Severity of health disorders	**Easy**	**Moderate**	**Severe**	**Very severe**
Description of symptoms	Symptoms are controlled with treatment or there are periodically mild symptoms despite treatment	Despite continuous treatment, mild symptoms or intermittent moderate symptoms persist	Despite continuous treatment, moderate symptoms or periodic severe symptoms persist	Despite continuous treatment, severe symptoms or periodic very severe symptoms persist
Physical examination data	Physical state is found normal or periodically mild	Despite continuous treatment, the physical state is found mild or intermittent	Despite continuous treatment, the physical state is found is moderate or intermittent	Despite continuous treatment, the physical state found severe or periodically very severe
Laboratory instrumental examination data	No changes or periodic changes	Despite continuous treatment, slight changes or periodic moderate changes remain	Despite continuous treatment, moderate changes or periodic severe changes remain	Despite continuous treatment, severe changes or very severe changes over time persist

Source: Annex 5 to the Cabinet Regulation No. 805.

Based on the Medical Report and using the above table, the SMC expert assessor evaluates the severity of the applicant's health disorders. The severity of health disorders is determined from the description of symptom, physical examination information and laboratory investigation data. One would expect that the Medical Report contains complete and accurate information on all three, supported by relevant medical documentation. No evidence is available whether this is the case. Moreover, no description of each term used to describe symptoms and physical examination qualifiers is offered (e.g. what in physical examination "mild" or "moderate" or "severe" or "very severe" means and how one clearly differentiates between them).

According to the Health Disorders Assessment Table:

*A **mild degree of health disorders*** exists if the symptoms are controlled by treatment or mild symptoms are periodic, regardless of treatment, physical examination findings are normal, or periodically mild, and laboratory instrumental examination data show no change or only a slight change.

A ***moderate degree of health disorders*** is determined if mild symptoms persist despite continuous treatment, or moderate symptoms exist periodically, despite continuous treatment, and data from physical examination show mild or periodically moderate symptoms and slight changes or periodically moderate changes remain as measured through laboratory instrumental investigations.

A severe degree of health disorders is determined in cases when, despite continuous treatment, moderate symptoms persist or there are severe symptoms on a periodic basis, physical examination finds moderate or periodically severe symptoms and moderate or periodically severe changes remain as measured by laboratory instrumental investigations.

A very severe degree of health disorders is determined in cases when, despite continuous treatment, severe symptoms persist or there are very severe symptoms periodically, physical examination data finding show severe or periodically very severe state and severe changes or periodically very severe changes are found in laboratory instrumental investigation data.

The Functioning Ability Evaluation Table contains a small selection of body function One-Level Classification groups (4 out of 8) and activity and participation domains (5 out of 9) with a total of 21 (see Table 3.7 for an excerpt) out of over 200 Two-Level Classification items from the WHO ICF[87] (See Box 3.1 for basic information on ICF):

- *Body functions*: specific mental functions, sensory functions and pain, cardiovascular, hematopoietic, immune and respiratory system functions, nervous-musculoskeletal and motion-related functions;
- *Body structures*: none
- *Activity and Participation domains*: learning and knowledge use, communication, mobility, self-care, interaction and relationships with other people.

Table 3.6 -An excerpt from the "Functioning ability evaluation table"

Functioning domains and categories (according to ICF)	**Notes**
1. Specific mental functions 1.1. b140. Attention (persistence, change, breakdown) 1.2. b144. Memory (short-term, long-term) 1.3. b164. Advanced cognitive functions (abstraction, organization and planning, comprehension, reasoning, problem solving)	**Attention** - evaluates the concentration of attention in the required period of time, the change of attention, as well as its division into two or more stimuli at the same time. **Memory** - Evaluates short-term and long-term memory. **Abstraction** - a logical process in which the thought deviates from the insignificant, random features of an object or phenomenon and separates, fixes their general and essential features. Abstraction - creation of abstract concepts; generalization. **Organization** - to unite, unite (what) in a certain whole, in a system (usually to achieve a goal). Sort, create (what) planned, coordinated. **Planning** - an ability and / or process that ensures the gradual, sequential, purposeful and effective behavior. **Self-awareness** - awareness and understanding of oneself and one's behavior. **Judgment** - the ability to form a judgment. **Problem solving** - the ability to identify and analyze conflicting information and find a solution
Degree of restriction: 0 – no restriction; 1 - mild restriction; 2 – moderate restriction; 3 – severe restriction; and 4 – very severe restriction.	

Source: Annex 5 to the Cabinet Regulation No. 805.

[87] WHO ICF: https://www.who.int/classifications/icf/en/

Box 3.1 World Health Organization International Classification of Functioning, Disability and Health – WHO ICF at a glance

The overall aim of the ICF classification is to provide a unified and standard language and framework for the description of health and health-related states. The domains (understood as a practical and meaningful set of related physiological functions, anatomical structures, actions, tasks, or areas of life) contained in ICF can be seen **as *health domains*** and ***health-related domains***. These domains are described from the perspective of the body, the individual and society in two basic lists: (1) Body Functions and Structures; and (2) Activities and Participation.

As a classification, ICF systematically groups different domains for a person in a given health condition (e.g. what a person with a disease or disorder does do or can do).

Functioning is an umbrella term encompassing all body functions, activities and participation.

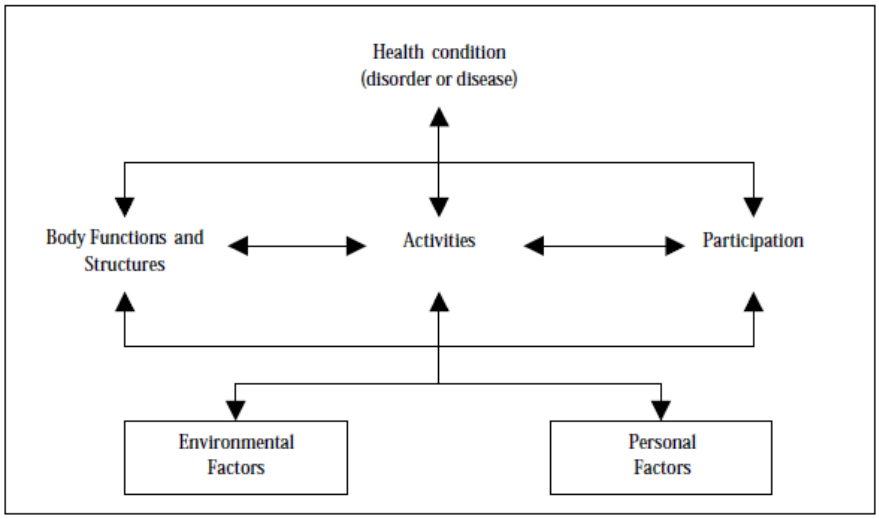
Disability serves as an umbrella term for impairments, activity limitations or participation restrictions. ICF also lists environmental factors that interact with all these constructs. In this way, it enables the user to record useful profiles of individuals' functioning, disability and health in various domains. ICF belongs to the "family" of international classifications developed by WHO.

ICF provides a description of situations with regard to human functioning and its restrictions and serves as a framework to organize this information. The body component comprises two classifications, one for functions of body systems, and one for body structures. The chapters in both classifications are organized according to the body systems. The activities and participation component covers the complete range of domains denoting aspects of functioning from both an individual and a societal perspective. Contextual factors comprise environmental factors and personal factors (personal factors are not classified in ICF because of the large social and cultural variance associated with them).

The ICF uses the following definitions: In the context of health:

- **Body functions** are the physiological functions of body systems (including psychological functions).
- **Body structures** are anatomical parts of the body such as organs, limbs and their components.
- **Impairments** are problems in body function or structure such as a significant deviation or loss. **Activity** is the execution of a task or action by an individual.
- **Participation** is involvement in a life situation.
- **Activity limitations** are difficulties an individual may have in executing activities.
- **Participation restrictions** are problems an individual may experience in involvement in life situations.
- **Environmental factors** make up the physical, social and attitudinal environment in which people live and conduct their lives.

Interactions between the components of ICF (the resulting outcome is disability)



An overview of ICF

	Part 1: Functioning and Disability		Part 2: Contextual Factors	
Components	Body Functions and Structures	Activities and Participation	Environmental Factors	Personal Factors
Domains	Body functions Body structures	Life areas (tasks, actions)	External influences on functioning and disability	Internal influences on functioning and disability
Constructs	Change in body functions (physiological) Change in body structures (anatomical)	Capacity Executing tasks in a standard environment Performance Executing tasks in the current environment	Facilitating or hindering impact of features of the physical, social, and attitudinal world	Impact of attributes of the person
Positive aspect	Functional and structural integrity	Activities Participation	Facilitators	not applicable
	Functioning			
Negative aspect	Impairment	Activity limitation Participation restriction	Barriers / hindrances	not applicable
	Disability			

Source of information presented in this Box: WHO ICF. https://www.who.int/classifications/icf/en/

Annex 5 to the Cabinet Regulation No. 805. defines the qualifiers to describe functioning in terms of restrictions: 0 – no restriction; 1 - mild restriction; 2 – moderate restriction; 3 –severe restriction; and 4 – very severe restriction. and notes (indicating the information to be considered when evaluating the relevant function).

In the Notes to the Tables I and II of the Annex 5, the expert assessors are instructed that when performing an assessment of functioning abilities and determining the degree of function or activity restriction (mild, moderate, severe or very severe) to consider how the functioning or activity restriction manifests itself, the performance of the activity, the pace, energy consumed, and the result achieved.

Based on the results of the assessment of health disorder and abilities of functioning, expert assessor of SMC proposes a decision on the severity of disability and loss of working ability in percent.

No disability: If no functioning restrictions are found or carrying out an activity is easy – it does not cause significant problems to function - disability is not determined. The individual could still be identified as having a loss of general ability to work for up to 24.0 percent, but this is not regarded as a disability for the purposes of the assessment.

Group III disability: Functioning restrictions are moderate if functioning is substantially limited, but not so much that the restrictions would be severe (daily activities can be done independently, but at a substantially slower pace or with more effort, or worse quality compared to the normally accepted standard for the corresponding age group). Group III disability is determined, where the loss of ability to work is assessed at 25.0-59.0 percent.

Group II disability: Functioning restrictions are severe if functioning is substantially limited, restriction is higher than moderate, but is not very severe (most of daily activities can be done independently, but at a substantially slower pace or with more effort, or worse quality compared to the normally accepted standard for the corresponding age group, with episodic need for help or supervision. Group II disability is determined, where the loss of ability to work is 60.0-79.0 percent.

Group I disability: Functioning restrictions are very severe if functioning is very limited or practically impossible (need for permanent or frequent episodic help or supervision in daily activities). Group I disability is determined, where the loss of ability to work is assessed as 80.0-100.0 percent.

Looking at the sources of information for disability assessment (Medical Report and the Functioning self-assessment) and criteria for assessment in Annex 5 to the Cabinet Regulations No. 805, the consistency across information sources and criteria is not obvious. The choice of ICF items is not obvious either: no justification is given for the first level ICF domains that were chosen, or why the others are excluded; nor is any justification given for why specific Second level domains were selected rather than others in the same group. Without justification, the basis for the choice is puzzling and seem arbitrary.

3.5.4 Disability and work ability in cases of occupational health

In cases, where an assessment is conducted due to an accident at work or occupational disease, or a disease, which is related to the consequences of the accident at the Chernobyl Nuclear Power Plant (further Chernobyl NPP) the assessment of a disability group and/or loss of ability to work in percentage is carried out based on a list of diseases and assigned percentages of work incapacity to each one of them (a version of a traditional Barreme grid or table of diseases/impairments and associated percentage loss of work capacity or percentage of disability. This table is provided in the Annex 6 *"Criteria for the Assessment of the Loss of Ability to Work in Percentage for Persons Suffering*

from and Accident at Work or Occupational Disease, or a Disease Related to the Consequences of the Accident at the Chernobyl Nuclear Power Plant" to the Cabinet Regulation No. 805[88]. The Annex also includes two additional tables: "The loss of ability to work (in percentage) depending on visual acuity reduction" and "The loss of ability to work (in percentage) depending on visual acuity reduction in case of trauma". See Table 3.5 for an excerpt from the Annex 6 Barreme table.

Table 3.7 -An excerpt from the "Criteria for determining the percentage of incapacity for work for persons injured in an accident at work, suffering from an occupational disease or an illness related to response to the Chernobyl NPP accident"

	Health disorders	Loss of ability to work (%)
1.	**Tuberculosis** (SSK-10: A15-A19; B90)	
1.1.	Clinically treated tuberculosis with mild tuberculosis organ dysfunction	0-24
1.2.	Clinically treated pulmonary and extrapulmonary tuberculosis with post-tuberculous changes and moderate organ dysfunction	25–59
1.3.	Active pulmonary and extrapulmonary tuberculosis with organ dysfunction and the need for long-term specific treatment in an inpatient or outpatient setting (patients receive medication in the presence of a medical professional). There is a possibility of infection	60–79
	Clinically treated tuberculosis with extensive post-tuberculous changes in the lungs after surgery (pulmonectomy or partial lung resection): a) cirrhosis; (b) thin-walled cavities; (c) atelectases; d) bronchiectasis; e) pulmonary fibrosis; (f) post-tuberculous deforming bronchitis with exacerbations during the year; (g) Grade II-III respiratory distress, pulmonary heart failure with or without pulmonary heart failure	
	When assessing the consequences of extrapulmonary tuberculosis (tuberculosis of other organs with organ dysfunction), organ dysfunction should be taken into account: (a) renal failure in the presence of renal tuberculosis; (b) severity of musculoskeletal disorders in the presence of tuberculosis of the spine and bone	
1.4.	Chronic progressive pulmonary and extrapulmonary tuberculosis with tuberculous intoxication and / or pulmonary hypertension and / or right ventricular dysfunction, adverse prognosis	80-100

Source: Annex 6 to the Cabinet Regulation No. 805.

In deciding on the final percentage of work incapacity, in addition to the information from the Bareme table, other information plays a role too: whether a person has other significant health problems, the impact of the impairment on everyday life activities, as well as the person's age, education, work experience, labor status, competitiveness in the labor market and job forecasts. Like in the case of non-occupational health conditions: if the loss of ability to work is in the range of 25.0-59.0 percent Group III disability is determined; if the loss is in the range of 60.0-79.0 percent, Group II disability is determined, and if the loss of ability to work is higher than 80.0 percent, Group I disability is determined.

[88] *Ibid.*

3.5.5 Case assessment report

A case assessment report is prepared by a designated expert assessor after: (i) s/he has reviewed the documents and assessed the applicant's health disorders and their severity, as well as her/his functioning abilities and their restrictions; and/or (ii) reviewed the questionnaire pertaining to everyday activities and environment, if the assessment is conducted in order to determine medical indications for special care. Should it be needed, the expert assessor can request additional information and/or additional medical examination. Based on the documents and criteria set in the Cabinet Regulation No. 805, the expert assessor provides her/his conclusions and recommendations.

It should be noted that to ensure uniformity in the assessment, the SMC`s internal regulations specify that criteria defined in annexes 3, 4, 5 and 6 to the Cabinet Regulation No. 805 should be used by all assessors and applied across the board.

The case assessment report should provide a comprehensive description of the assessment with conclusions and recommendations. The report once completed and signed is forwarded electronically to a SMC official for a decision.

3.6 Case assessment report review and decision making

An official of the SMC reviews the assessment report and decides on the applicant's disability severity group and loss of ability to work in percentage, as well as the cause and time period of disability. S/he determines:

- for children up to 18 years of age – disability in accordance with the Criteria for children;
- for working age adults – a disability group and a loss of ability to work in percentage in accordance with the Criteria for adults, the cause and time period of disability;
- for persons who have reached the age necessary for granting the state old-age pension – a disability group in accordance with the Criteria for adults, the cause and time period of disability;
- for working age adults with occupational health issues (accident at work, occupational disease, diseases related to the Chernobyl Nuclear Power Plant disaster) - a disability group and/or loss of ability to work in percentage in accordance with the Annex 6 to the Cabinet Regulation No. 805, the cause and time period of disability.

For adults the cause of disability indicated in the decision is generally "a disease". However, in some cases, some other causes can be indicated.[89]

Disability and loss of ability to work is determined for six months, one, two or five years or for life. For children, based on an established medical diagnosis, disability can be determined for a period until they reach the age of 18, if anatomical defects or health disorders are detected in accordance with the "List of Anatomical Defects and Health Disorders for Determination of Disability" ("Up to 18 years of age" or "Without a repeated period for a disability expert-examination (for life)").[90] Similarly, for adults, disability and loss of ability to work can be determined without the need for a new assessment

[89] They include: a disease from childhood (for a child up to 18 years of age), accident at work, occupational disease, disease related to the participation in the response to the accident at the Chernobyl Nuclear Power Plant or to being located in the accident zone of the Chernobyl Nuclear Power Plant, disease or injury acquired during participation in response/ rescue operations in emergencies, injury or diseases contracted during military service, injury or disease contracting while discharging official state business (the President, a Member of the Parliament, a member of the Cabinet, a Parliamentary Secretary, a civil servant, etc.), and others.

[90] "The List of Anatomical Defects and Health Disorders for Determination of Disability" ("Up to 18 years of age" or "Without a repeated disability assessment (for life)"); Annex 7 to the Cabinet Regulation No. 805. https://likumi.lv/ta/id/271253-noteikumi-par-prognozejamas-invaliditates-invaliditates-un-darbspeju-zaudejuma-noteiksanas-kriterijiem-terminiem-un-kartibu.

(for life), if the person has anatomical defects or health disorders listed in the mentioned "List"[91] or has a stable and irreversible functioning restrictions due to which the disability has been previously determined continuously for not less than five years (i.e. where a person has had several reassessments in the past which have all resulted in a repeated determination of disability).

Concurrently with making the decision to determine disability or loss of ability to work or after the decision, an official of the SMC provides opinions on the medical indications for i) acquisition of a specially adjusted car and the receipt of an allowance for the compensation of transport expenses; ii) the necessity of special care; iii) exemptions for the commencement of the naturalization procedure for the acquisition of Latvian citizenship; iv) the extension of a sick-leave certificate during transitional work disability period, which continues for more than 26 weeks; v) the necessity of the service of an assistant and recommendation for inclusion of social and vocational rehabilitation services into an individual rehabilitation plan for a person with a predictable disability.

Recommendations can be given regarding the inclusion of social and vocational rehabilitation services in an individual rehabilitation plan for a person with a predictable disability. The recommendation to include social and vocational services in an individual rehabilitation plan is binding for the doctor and social service office (to include social and vocational rehabilitation services in an individual rehabilitation plan). The person has right to reject the recommendations. In that case, s/he loses the opportunity to receive services paid by the state.

3.7 The issuance of disability decision, appeals and grievance redress

The decision on disability is transferred to SMC Client Service that notifies the applicant about the decision, opinions and recommendations, in accordance with the Law on Notification, that regulates the issuance on notifications.[92] While the time period within which a notification should be sent to the applicant is not specified, it usually happens within few days after the decision.

If the applicant is not satisfied with the decision, s/he may contest it with the SMC Head within one month after the formal notification date. The decision of the SMC Head can be appealed to the Administrative District Court.

A person with disability or loss of ability to work has the right to request a repeat at any time, if her/his state of health and functioning has deteriorated significantly and is considered to have reached a stable state in which no improvements are expected.

3.8 Observations concerning the disability assessment administrative process and assessment criteria

The administrative process is relatively simple and straightforward. However, while simplicity is its strength, it is also its weakness in the absence of a fully developed management information system and a more comprehensive, consistent and standardized assessment criteria.

The evaluation process is entirely paper based, without a face to face interaction between an applicant and SMC. Disability is complex, dynamic and evolving human condition and face to face interaction is essential for an objective and valid assessment.

[91] The List includes, for example, anatomical defects such as lack of limbs, health disorders such as gastrectomy, heart valve prosthesis, etc. The anatomical defects and health disorders should be listed in the Form u-088.

[92] The Law on Notification 2010. Riga: Saeima: https://likumi.lv/ta/id/212499-pazinosanas-likums.

The Medical Report is the most important document in the current process. It is the document on basis of which the decision on disability is made by SMC. It is assumed that the medical practitioner will provide detailed and substantiated information about the applicant's primary, secondary diagnoses and co-morbidities with ICD codes and an accurate and complete description of the state of body functions and body structures and activities and participation with appropriate qualifiers as in the ICF. It is, however, not clear to what extent this is the case as most often the medical report is filled out by hand and in a free-flowing format (there are blanks to write in). As noted above, the full implementation of the E-Health system and moving from paper based to electronic filing of the medical report will provide a significant opportunity to improve and standardize information provided in it. Moreover, it will enable that information is recorded and saved in the electronic personal file and available for future assessment, but also for research.

The self-assessment is also mostly filled out as a paper document and submitted as such to SMC. Ideally it will be filled out and submitted in electronic form, without the need to print it out and submit in a paper format. Furthermore, the self-assessment forms are not saved in SMC Disability Information System so there are no possibilities to analyze the data or use them to cross check medical and information on activities and participation. There is no statistics on how many forms were submitted in paper format and how many as electronic files. Most importantly, according to the interviews with SMC representatives conducted for the purpose of this study, the self-assessment forms are not used as significant information in disability assessment process, because in many cases the information is considered inaccurate, there is lacking information and the perception is that the applicants exaggerate difficulties to increase their chances of getting a more severe disability.[93] There is no possibility to juxtapose and compare the self-assessment with the results from the medical report to determine consistency. In the future, the information on the experience of disability should optimally be collected electronically, by means of a self-contained, empirically well-tested instrument, and a face-to-face interview with a medical professional experienced in functioning (ideally, rehabilitation professionals). The information should be scored and integrated with the state of health information in an empirically based algorithm. To that end, and after the piloting of the WHODAS 2.0 – 36 questions version is concluded, MOW should consider replacing the current self-assessment questionnaire with WHODAS 2.0/36 Qs.

The SMC is planning to move to electronic filing of the self-assessment questionnaire. Where and how is still being discussed, but this intention will need to be reviewed in accordance with recommendations of this Report where it suggests that the functioning questionnaire should be filed out by a trained SMC professional in a face to face clinical interview. However, it seems that a review of the SMC DIS is of some urgency and that a systematic overhaul of the current system may have more merits than piece mill changes that may not contribute to a fully integrated system.

Latvia has made an important shift in disability assessment by moving from an assessment of impairments alone to a full assessment of functioning based on the ICF. But the operationalization of the new approach has not been conducive to this shift and the assessment is still largely based on medical state of an applicant. One set of improvements, pertaining to the administrative process and the need to completely shift SMC operations towards an electronic based platform was discussed

[93] An evaluation of 200 self-assessment forms (60 with mental health disorders) conducted in 2014 as part of the piloting of the self-assessment questionnaire found that some information was not accurate. Some respondents did not understand the questions, especially older participants and non-Latvian speakers. On the other hand, 76.7 percent of SMC experts who participated in the pilot project believed that the information provided in self-assessment forms and analyzed together with medical information would be enough for disability assessment without the applicant's participation. They also believed that, although, the information provided in self-assessment forms was a good tool to provide better insights about the applicant, the answers should not be scored because there were significant differences in medical conditions. This opinion signals lack of familiarity with the new approach to disability (UNCRPD), ICF and how to measure disability.

above. The other pertains to the criteria as currently defined in Annexes 3-6 to the Cabinet Regulation No. 805.

Criteria to assess disability in adults which is currently split between general health conditions and occupational diseases needs to be consistent and applicable across the board. In that sense, the question is whether singling out occupational related health conditions is justified, particularly given that using an impairment based Barreme table for this set of health conditions is inconsistent with the ICF and the functioning approach to disability assessment Latvia has adopted. The MOW should therefore consider using the functioning assessment uniformly, for all health conditions, irrespective of their origin (general, or occupational health). There should be no difference in the assessment method.

3.9 State Medical Commission for the Assessment of Health Condition and Working Ability (SMC)

3.9.1 Organizational structure, staff and budget

SMC is a public administration institution subordinated to the MOW. SMC assesses disability and determines whether an applicant has a disability under the Law. SMC has 10 departments, two located in the capital Riga – united department of Riga and specialized department of Riga and eight regional departments located in cities across regions – Daugavpils, Gulbene, Jelgava, Jēkabpils, Kuldīga, Liepāja, Rēzekne and Valmiera (Figure 3.3).

SMC expert assessors (medical doctors) who have been certified as such conduct predictable and disability expert assessment. Expert assessors are independent discharging their duties.

The tasks of SMC also include[94]:

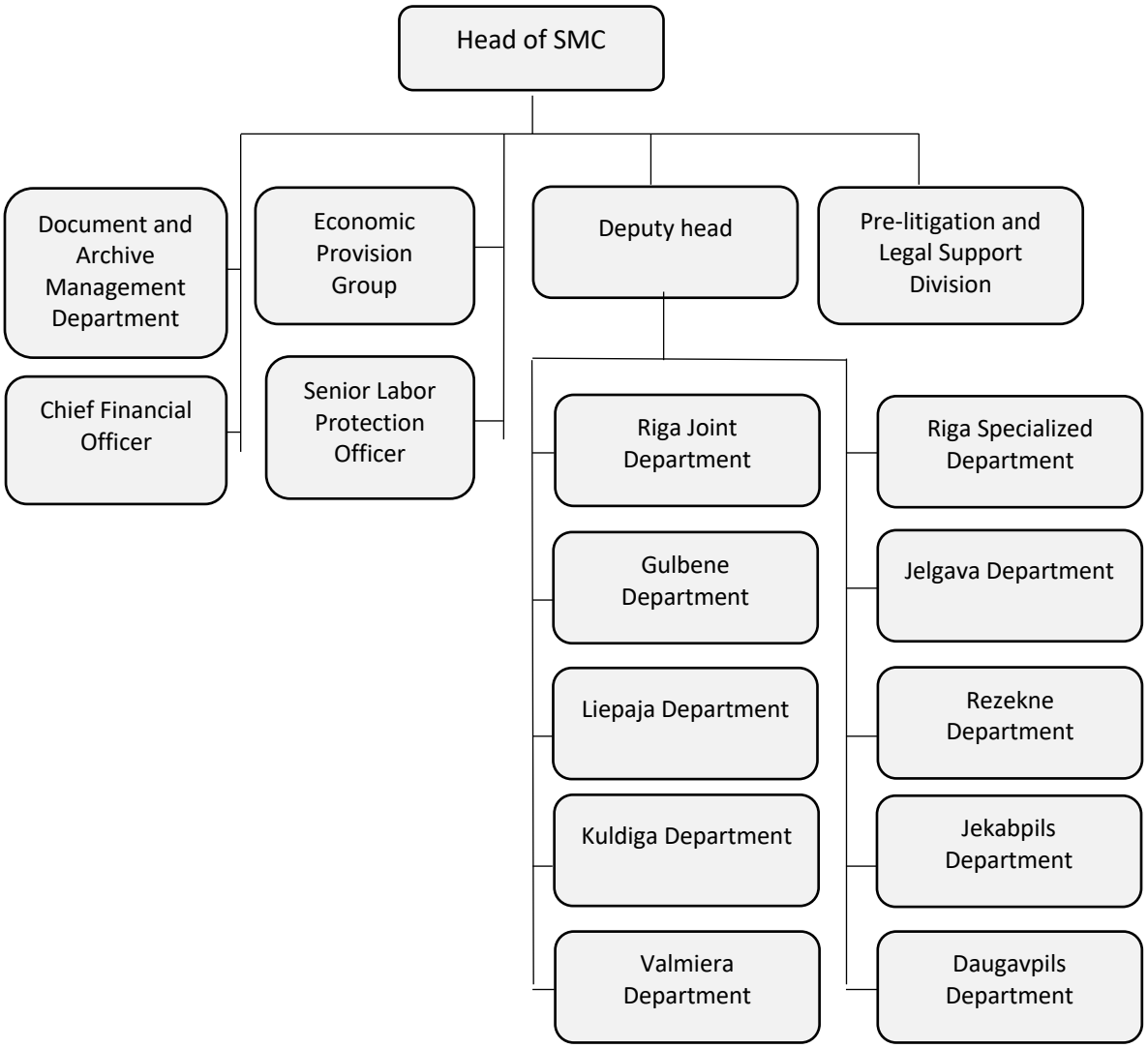
- Counselling interested individuals on SMC issues;
- Preparation of documents to SSIA on persons with disabilities identified in Latvia in accordance with the European Parliament and Council regulation on the coordination of social security systems and bilateral transnational agreements on cooperation in the field of social security;
- Disability determination in accordance with the European Parliament and Council regulation on the coordination of social security systems and bilateral transnational agreements on cooperation in the field of social security;
- Cooperation with treating physicians and local government social service offices;
- Organization and management of the operations of the DIS;
- Compilation and analysis of data on predictable disability and disability assessment and making proposals to MOW on relevant policy planning documents and legal acts;
- Inform the public on the SMC operation and perform other tasks specified in regulatory acts.

The head of SMC is appointed and dismissed by the MOW. She/he is a civil servant who determines the internal organizational structure of SMC and is responsible for establishing and operating an internal control and management decision-checking system. S/he directly manages the Document and Archive Management Department, Pre-litigation and Legal Support Division, Economic Provision Group, Chief Financial Officer, Senior Labor Protection Officer and Deputy Head. The Deputy Head manages regional SMC departments.

[94] The Statute of the State Medical Commission for the Assessment of Health Condition and Working Ability, 2011. SI 2011/315. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/229374-veselibas-un-darbspeju-ekspertizes-arstu-valsts-komisijas-nolikums

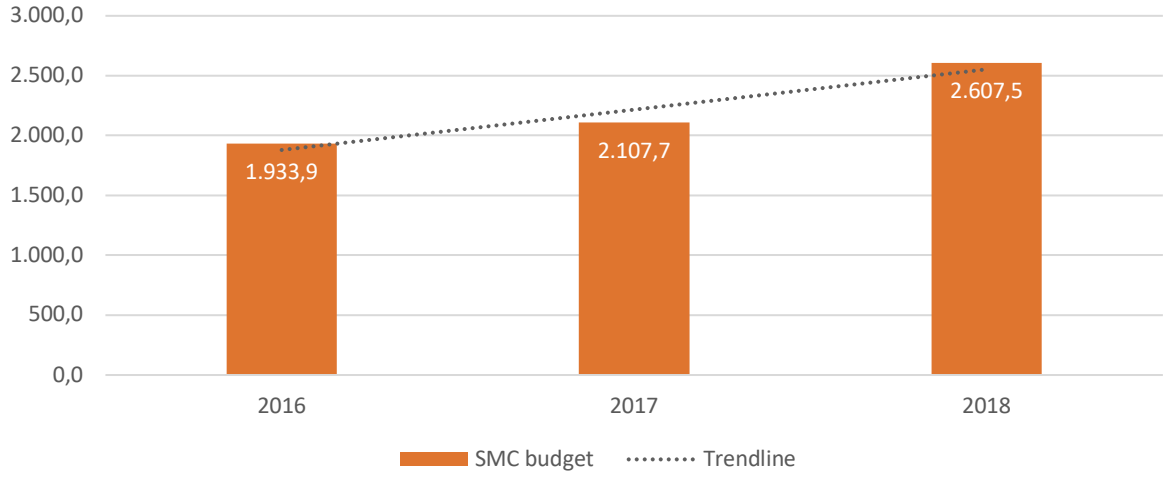
In 2018, SMC had an average of 146 employees. The changes in the number of SMC staff between 2016 and 2018 have been minor. A vast majority of SMC staff are women (over 80.0 percent) and most employess (over 70.0 percent) have higher education. About 1/3 of staff are at the retirement age (age at which they can draw an old-age pension) or above it; 14.0 percent of employees are older than 71 years. While an excellent example at keeping older adults employed, SMC staff is ageing and there should be a planned effort to educate and attract new medical experts.

Figure 3.4 -Organizational structure of SMC in 2018



SMC is fully funded from the state budget. In 2018, its total budget was EUR 2.6 million. Compared to 2016, the budget increased by more than one third (34.8 percent), see Figure 3.4.

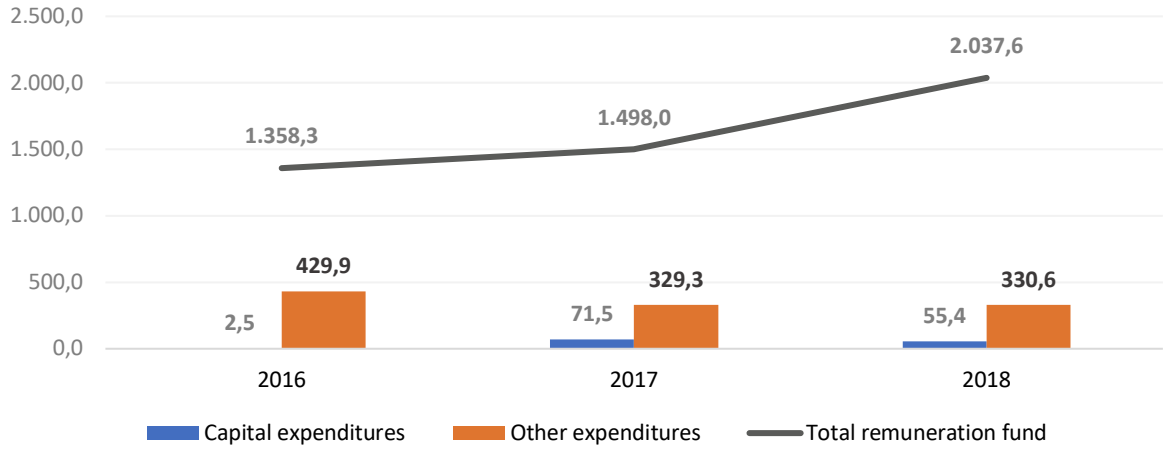
Figure 3.5 -SMC budget 2016-2018 (in 000 EUR)



Source: MOW.95

The SMC wage bill is its largest expenditure item: 75.9 percent in 2016 and 84.1 percent in 2018. Operational expenditure and capital investment are small, and the share dropped from 24.1 percent in 2016 to a very small 15.9 percent in 2018 (Figure 3.5). Given that the number of SMC stuff remained stable over the same period, the conclusion is that the increased budget went into a unit salary increase. This can be explained by the large economic impact after the economic crisis in 2008 when the budget and wages for SMC staff was cut and it is only now returning to previous levels; also, SMC must keep up with the wages of medical staff in the health sector in order not lose staff. The consequence was a very significant drop in the relative shares of operational cost and capital investment. At the same time, SMC's DIS needs a major improvement.

Figure 3.6 -SMC budget by major expenditure categories (000 EUR)



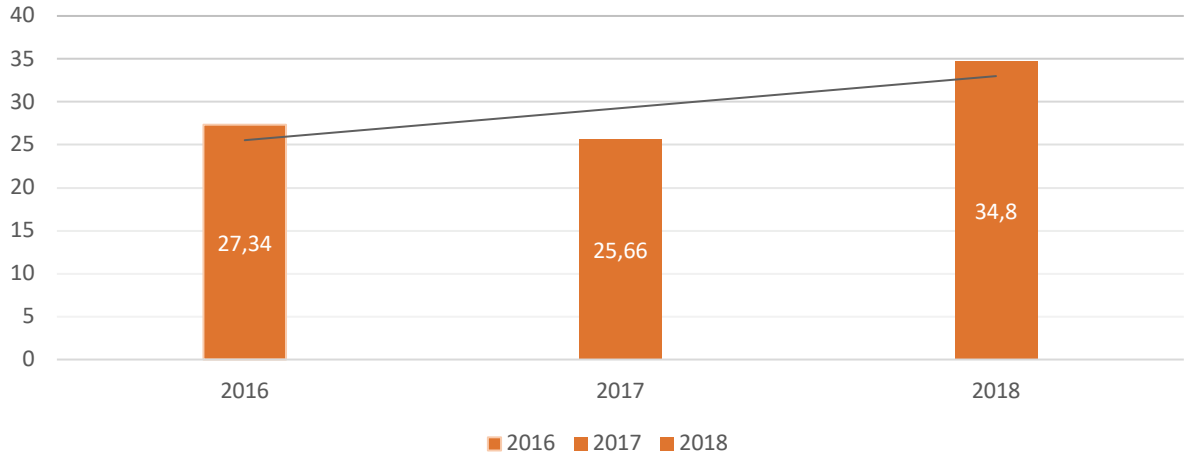
Source: MOW.[96]

[95] Ministry of Welfare. Public Overview of 2018. 2019. Riga: Ministry of Welfare: http://lm.gov.lv/lv/par-mums/publiskais-parskats

[96] Ministry of Welfare. Public Overview for 2016, 2017, 2018. 2019. Riga: Ministry of Welfare. Available at: http://lm.gov.lv/lv/par-mums/publiskais-parskats

Assuming that a unit cost of an on-site and off-site expert assessment is the same, the average cost of one disability expert assessment (calculated as the SMC total budget/number of assessments) was EUR 27.34 in 2016 and EUR 34.8 in 2018. The unit cost increased by 27.3 percent (Figure 3.6) on the account of the SMC staff salaries increase.

Figure 3.7 -Disability assessment unit cost (per one assessment) in EUR



Source: SMC[97]

3.9.2 SMC Disability Information System

Information obtained during the disability and predictable disability assessment process is processed and stored in the SMC DIS, according to Cabinet Regulation No. 381 "Regulation on Disability Information System".[98]

The current SMC DIS was developed in 2006, with upgrades in 2011 and 2015. However, relative to actual needs and requirements, it is outdated, and it does not comply with the good practice of the personal data processing regulations. SMC DIS is integrated only with OCMA, from which civil registry type of information about the person is provided. The information from/to other institutions is provided by data file exchange using predefined data files and copying them to SFTP servers or by selecting data from the SMC database, using Web services. The existing system doesn't have an integration with national Single Health Information System (E-Health).

Currently, there is an ongoing project to update SMC DIS (2019-2022), that will significantly change the overall approach, ensuring the system that is based and developed on business processes and providing necessary access to data, as well as the storage of personal information according to requirements of The General Data Protection Regulation. The new system development follows an iterative approach: first reworking and providing existing and necessary functionality (the first half of the 2020); then during the 2nd and 3rd rounds of the project, the additional functionality and necessary data exchange, as well as improved e-services will be developed.

[97] Annual Public Reports. State Medical Commission for the Assessment of Health Condition and Working Ability. Available at: http://www.vdeavk.gov.lv/wp-content/uploads/2014/09/Publiskais_gada_parskats_2017.pdf

[98] Ministru Kabinets. 20.08.2019 Noteikumi Nr.381 "Invaliditātes informatīvā sistēma". https://likumi.lv/ta/id/308895-invaliditates-informativas-sistemas-noteikumi

Annex 6 to this Report provides detailed description and analysis of SMC DIS, identifies its gaps and provides recommendations for its enhancements, to improve user experience, ensure efficient SMC operations and provide data on disability measurement that is necessary to monitor and analyze disability trends and for evidence based continuous improvements in the disability assessment system and methodology.

3.9.3 SMC operations at a glance (see also Chapter One)

According to SMC and as noted previously, the number of people with disabilities in Latvia has increased every year for a decade. As an example, while in 2016, 9.34 percent of the population were disabled,[99] in 2018, this proportion increased to 10.65 percent.[100] This is due not only to the increased number of people with disabilities, but also to the decline in the population.

During the last few years, SMC has been assessing close to 70,000 people per year. The total number of applications increased by 1.9 percent or by 1,223 applications between 2016 and 2018. The determination of disability for the first time increased by 12.5 percent (by 2,839), the determination of repeated disability increased by 10.7 percent (by 4,236). The number of persons to be assessed for predictable disability decreased by 47.9 percent: in 2016 there were 73 persons and in 2018 only 38 persons.

The most significant change is observed in the number of issued opinions: opinions on the need for assistant service increased by 30.5 percent (by 3,461), the need for an adjusted vehicle/transport allowance by 22.7 percent (by 2,769). The number of opinions regarding the extension of temporary incapacity to work increased by 18.6 percent. The number of opinions on the need for special care increased by only 3.5 percent.

The number of issued disability cards increased by 4.0 percent. A total of 67,155 disability cards were issued in 2018 (66593 in 2016). Persons may receive their disability card repeatedly during their disability term: in case they have lost it, it is older than 10 years, etc.

The number of applications submitted electronically is less than 1.0 percent, although it has been growing (from 0.5 percent in 2016 to 0.85 percent in 2018). The small number of electronically received applications could be explained by the fact that along with an application a person must submit the medical Form u-088/u and a self-assessment form. These documents are filled in manually, not electronically.[101]

The number of contested decisions increased by 26.0 percent between 2016 (1,614) and 2018 (2,022). This increase could likely be attributable to the determination of disability without the presence of a person, as well as the increased awareness of how to claim the rights and contest of the decision.

According to SMC,[102] the high demand for disability assessment and its opinions is driven by unfavorable socio-economic situation in the country. Limited availability of state provided medical care services is one of the main problems. Due to the lack of resources, there are long waiting times lasting for months to receive laboratory investigations and specialists' consultations (because there are limits (quotas) on the number of these services that the state will pay for), and necessary medical

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[99] In 2016, the population was 1,950,116; the number of people with determined disability was 182,048.
[100] In 2018, the population was 1,919,968; the number of people with determined disability was 204,494.
[101] Public Reports for 2017, 2018. Riga: The State Medical Commission for the Assessment of Health Condition and Working Ability.
http://www.vdeavk.gov.lv/wp-content/uploads/2014/09/Publiskais_gada_parskats_2017.pdf
[102] Public Report 2018, 2019. Riga: The State Medical Commission for the Assessment of Health Condition and Working Ability. Available at: http://www.vdeavk.gov.lv/par-mums/gada-parskati-un-petijumi/

rehabilitation services are poorly provided or not provided in due time. It is assumed that the lack of medical services/treatment, as well as the fact that support services are available to people, inter alia for elderly people in care need, mostly through the disability system requiring formal certification of disability to access them, have resulted in the increase in the number of people assessed for the first time for disability and having a very severe disability (Group I) reaching 27.0 percent of persons with disability.

Key findings and recommendations

Here we summarize key findings and recommendations provided throughout this chapter.

Findings

Moving from medical based disability assessment to an easement of functioning based on ICF. Latvia has made significant changes to its disability assessment system as of January 1, 2015: by moving from an assessment based solely on medical condition to an assessment that following the ICF, also takes into account functioning, or lived experience of persons with disabilities. To that end, (i) criteria for disability assessment were partially changed by selecting a sample of ICF items from body functions and activities and participation to guide the assessment, (ii) a self-assessment of functioning was introduced, and (iii) to decide on the care needs, a "Questionnaire of Assessment of Everyday Activities and Environment of the Person" filled out by a social worker or occupational therapist, was developed. The assessment become entirely based on the review of documents, on the assumption that information provided by a physician and a self-assessment form would be enough for an expert assessor to assess the state of health and functioning of a person and determine her/his disability and work capacity, as well as care need.

The medical to functioning shift is yet to take place: Although changes to the regulatory framework have been made with the aim of increasing the importance of functioning in disability assessment, in practice, no significant changes have taken place. Disability, severity of disability, loss of capacity to work are determined according to diagnosis, information provided by the medical practitioner on the health status of the person, medical examinations and consultations. People with disabilities still consider that prior to a repeated assessment of disability, it is better to have a medical record attached to the documents to be submitted to SMC.

The pace and depth of change critically depend on the operationalization and tools and resources to implement it: Legally, disability, severity of disability and work ability are to be assessed based on functioning restrictions a person with a health condition experiences in her/his life. However, criteria stipulated for disability assessment are not commensurate with the legal framework, there are inconsistencies between them and there is discrepancy between the criteria and information requested from medical doctors.

For instance, for occupational accidents and diseases, disability is determined based on diagnosis and impairments and associated percentage of loss of work capacity (a traditional Bareme grid). At the same time, the criteria instruct that a "percentage of loss of capacity to work is indicative and that the final degree depends on whether the person also has other significant health problems and their impact on daily life activities, as well as and on the age of the person, education, work experience, employment relationships, competitiveness in the labor market and on the labor market forecasts"[103]. In sum, in the case of occupational accidents and diseases, the percentage of the loss of capacity to work is determined first and then the corresponding disability group (considering the listed factors,

[103] *Ibid*. Annex 6. https://likumi.lv/ta/id/271253-noteikumi-par-prognozejamas-invaliditates-invaliditates-un-darbspeju-zaudejuma-noteiksanas-kriterijiem-terminiem-un-kartibu

such as age). However, these "other criteria" are arbitrary and discriminatory and should not relate to the determination of disability.

The opposite is done in the case of non-occupational accidents and diseases: first, restrictions in functioning and relevant disability group are determined and according to the disability group - the percentage of lost capacity to work. As noted, the domains of functioning included in the criteria are a small sample from a much larger ICF list and it is not clear how the choice of those items was made. Moreover, it is not clear who and when makes an assessment, for example, the extent, lightness and stability of joint movements, or muscle strength by scores, or memory function, as well as what tools are used for this purpose, particularly in the case when disability is determined for the first time. One would need to assume that these are asserted by expert assessors based on the diagnosis and the state of health provided by a GP or treating doctor in the medical report.

The assessment of functioning requires familiarity with the ICF – the interactional approach to disability and classification of body functions, structures, activities and participation and the role of contextual factors (environment and personal factors). For medical professionals with long work history and coming from the old tradition of medical determination of disability, the shift from diagnosis and related impairments to a full assessment of functioning may not come naturally. Moreover, rehabilitation interventions and support to optimize functioning and maximize participation in the labor market have become crucially important and should become an integral part of disability assessment, which is yet to be the case in Latvia.

Insufficient clarity and inconstancies lead to increased contestation: The number of contested decisions has increased following changes in the determination of a disability without the presence of a person. According to SMC, the main reasons for changing the decision and opinion or recommendation are: an incorrect assessment of health and functioning capacity (severity, duration, consequences of the disease are not assessed), insufficient information when taking a decision or issuing an opinion without requesting additional information); in complex cases the expert-assessment has been carried out without the presence of the client; information in the referral does not justify a reduction in the degree of functioning disorders.[104]

Predictable disability is determined rarely: a missed opportunity to focus on rehabilitation and improvements in functioning. The state support and access to medical/rehabilitation services for people who have been recognized as having a predictable disability are insignificant. Medical rehabilitation services to which they are entitled and on priority basis, based on their individual rehabilitation plans, are often not immediately available and the waiting lists are long. As a result, people opt to receive an extended sick leave based on SMC's opinion (up to another 26 weeks) or a disability status, rather than a predictable disability. In many ways, the currently insignificant role of predictable disability is a missed opportunity, particularly for employed, working age adults. Except for obviously severe cases, the predictable disability (if needed, combined with an extended sick leave) is an opportunity during which SMC, rehabilitation professionals, employment service, employers and MOW can come together to support a person to recover and stay in employment. As evidenced by many studies[105], once a person leaves the labor market due to disability, the chances of getting back into the labor market are small. Therefore, MOW has two options: (i) abolish predictable disability; or, preferably, (ii) turn it into a mandatory step prior to disability certification.

SMC needs significant strengthening. SMC staff is ageing, and the job is not attractive enough to draw young medical graduates. The work is not considered prestigious and the pay is not competitive. There

[104] Public Reports for 2016/2017; 2017/2018, and 2018/2019. Riga: The State Medical Commission for the Assessment of Health Condition and Working Ability. Available at: http://www.vdeavk.gov.lv/par-mums/gada-parskati-un-petijumi/
[105] See, for example, a series of OECD studies on work and disability.

are no occupational physicians and rehabilitation professionals are in short supply. The problem would need to be addressed by a multi-pronged approach, including (i) medical schools should offer relevant courses (on ICF, disability and its measurement and assessment, etc.); (ii) SMC in cooperation with MOH could offer stipends to rehabilitation medicine students to spend several years working at SMC; (iii) SMC could have on-boarding and other training courses in functioning and disability developed and implemented on annual mandatory basis; (iv) SMC staff could be incentivized to do research using SMC data (once it is available electronically). Face to face interviews would increase the job attractiveness, as medical doctors are trained to work with people, not paper. Another very important consideration is the information system that needs to be significantly strengthened. All business processes should be automated, with electronic handling of documents, an electronic archive system, and automated data exchange with other government data bases, including E-Health, civil registry, SSIA, local governments, etc. As a rule, all data on an individual used in the disability assessment system should be entered into the DIS and available for future assessments, but also used for research in anonymized format.

Recommendations

- As stipulated by pertinent legislation, disability assessment should focus on activity limitations and participation restrictions rather than on medical conditions and impairments alone. This implies further finetuning the disability assessment procedures, including a face to face interview, functioning assessment scoring and using an evidence-based algorithm for determining the extent of disability.
- Regulations pertaining to disability assessment, including criteria of assessment, and related health and social services should be reviewed and revised in order to achieve comprehensiveness and conceptual consistency. This requires a whole government approach and close collaboration between MOW, MOH, and other ministries responsible for different policy areas pertinent to disability.
- The government should consider abolishing predictable disability and replacing it with coordinated efforts to optimize functioning and participation of working age adults in the labor market. This will require the involvement of social services, medical and occupational rehabilitation professionals, employment services, employers, and others in order to objectively assess work capacity with a view of maximizing labor force participation. Services, assistive and technical aids, and work-place accommodation should be provided during this period. For consistency, the same tools for disability assessment should be used to assess functioning. It is essential that there be a close collaboration and coordination between SMC, MOW and MOH. All information from conducted assessments and services provided should be available to SMC, in case a person is assessed for disability.
- Disability certification should not be a precondition for persons to receive publicly financed services such as vocational rehabilitation, technical aids, workplace adjustment, etc. In some cases, particularly for employed persons, a range of services may be needed to prevent or mitigate disability and help the person stay in employment. This, however, does not imply that persons assessed as disabled should not get needed services. Quite the opposite. Furthermore, disability certification is needed for persons with disabilities to access benefits in cash and other benefits specifically targeted at persons with disabilities.
- Standardized, empirically tested assessment tools should be used to assess limitations in activities and restrictions in participation.
- The same criteria and valid tools for assessing disability should be used to assess work capacity whether or not the health condition is associated with occupational health or general health.

- Medical reports should be standardized and requested information should match disability assessment criteria.
- For first-time disability assessments, the functioning questionnaire should be filed out by a trained SMC professional in a face to face clinical interview. This interview should be conducted for predictable disability as well, irrespective of where and by whom it is conducted (on the assumption that predictable disability is transformed as recommended above). For reassessments, the medical report and self-assessment may continue, but with monitoring to assess effectiveness. The possible benefit of including instead a face to face interview should be kept available.
- The SMC should be strengthened by (i) developing human resources and (ii) overhauling the existing DIS. Staff should be trained in ICF, with regular refresher courses. Paper processing and paper records should be phased out in favor of electronic reporting. Along with MOW, SMC should become one of the major stewards of data to analyze Latvia's disability situation and to identify trends for better, evidence-based disability policy development.
- MOW should consider adding a needs assessment to disability assessment. Persons with disabilities could be advised which services are available to them and where to obtain them and the referral could be automatic. This would require changes in the staff complement that assesses disability and it could be planned in the medium term.

4. SUPPORT TO PERSONS WITH DISABILITIES

In this section we provide an overview of disability benefits provided to persons with disabilities in Latvia. Latvia provides a range of benefits to persons with disabilities through social insurance, social assistance, labor market and public health programs. Benefits range from cash benefits, to care services, social, medical and vocational rehabilitation and employment support, to residential placement. Support is provided at the state and national level, as well as by municipalities.

Photo credit: SSIA

As noted in Chapter Two, the *Constitution of the Republic of Latvia* states that everyone has the right to social security in old age, for incapacity for work, for unemployment and in other cases as provided by law. Support to persons with disabilities is regulated by various laws and associated regulations of the Cabinet. For example, the *Law on Social Security* lists the social rights, including the rights to support for education and employment, to social insurance, and to health care. All rights referred to are exercised by persons with disabilities as by other members of the society.

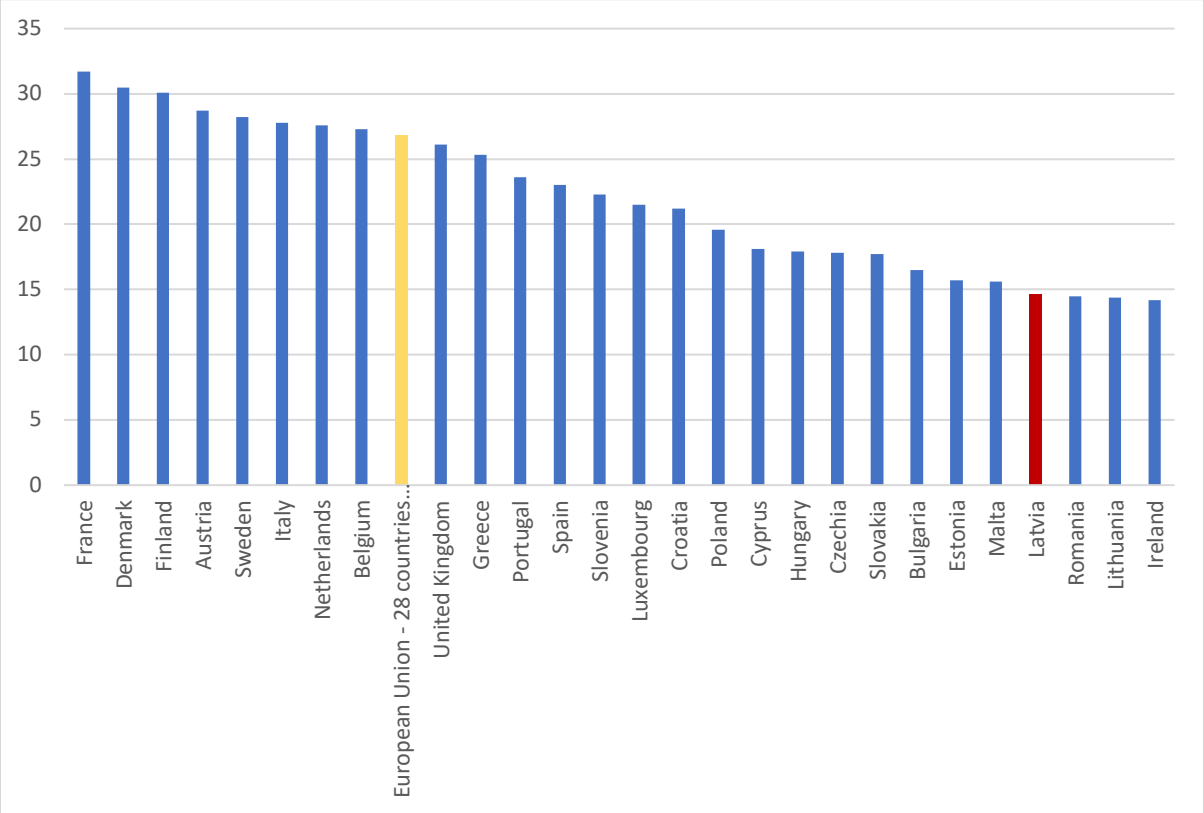
Information on state disability benefits is available on the webpages of responsible institutions. Information on support provided by municipalities is available on the portal *Likumi.lv* or on the webpages of respective municipalities. There is no single information portal where potential beneficiaries can find comprehensive information on available benefits, their eligibility criteria and administrative procedures to obtain them. Annex 8 to this Report provides detailed information on key programs.

4.1 Public spending on support to persons with disabilities in Latvia in the EU context

According to the latest available Eurostat data, Latvia spent 14.6 percent of GDP on social protection in 2017[106], the fourth from the bottom in the EU and well below the EU-28 average of 26.8 percent of GDP (Figure 4.1).

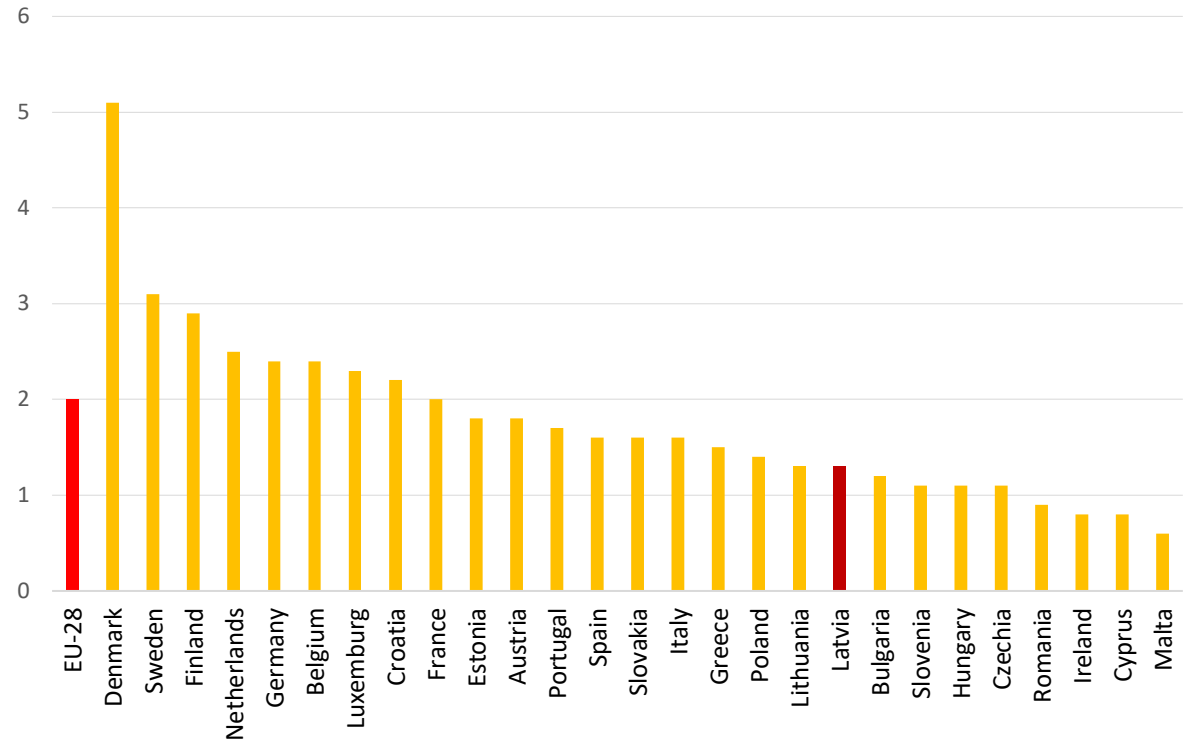
The spending on social protection has grown relatively fast in real terms between 2008 and 2017 – at an average annual rate of 2.4 percent (compared to 1.6 percent for EU-28).[107] Spending on disability benefits (Figures 4.2 and Table 4.1) in terms of GDP share is well below the EU-28 average (1.3 compared to 2.0 percent of GDP in 2017, respectively), placing Latvia among EU countries with the lowest level of spending relative to GDP. On the other hand, spending on disability as a fraction of the overall spending on social protection is higher in Latvia than the EU-28 average (9.05 compared to 7.56 percent) and places Latvia among the EU countries where this share is among the highest (the ninth from the top – Figure 4.3, Table 4.1).

Figure 4.1 -Expenditure on social protection benefits in EU in 2017



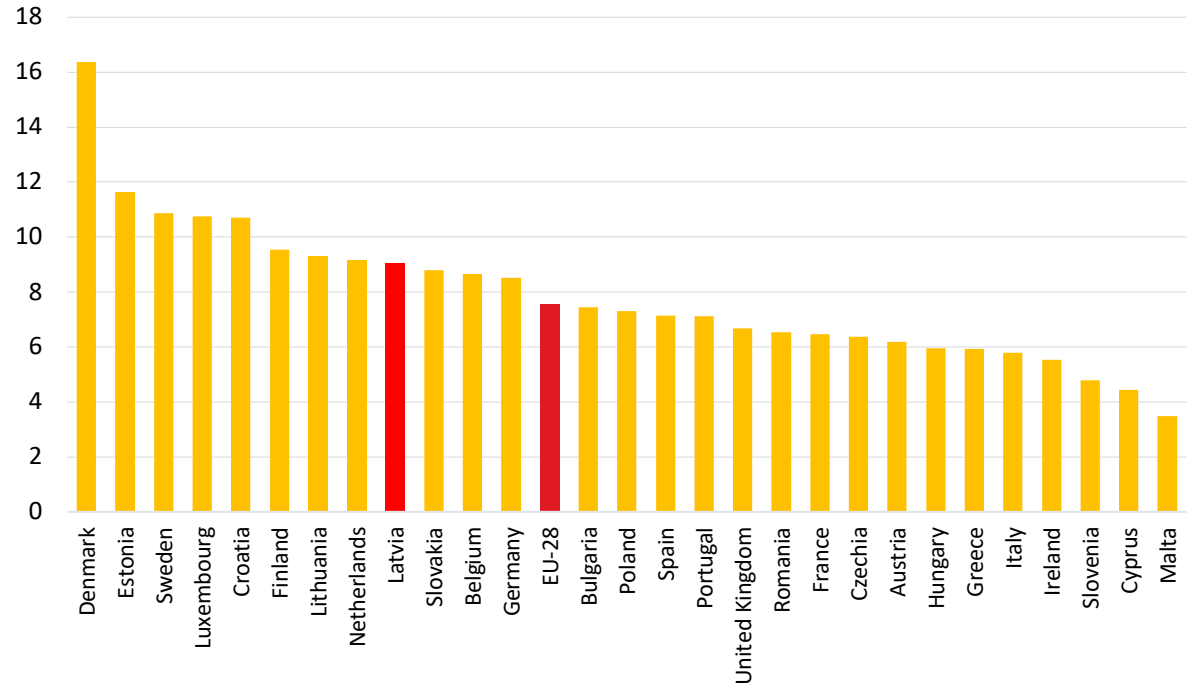
[106] As it will be seen throughout this chapter, Latvia increased spending on some disability programs in 2018.
[107] See: https://ec.europa.eu/eurostat/statistics-explained/images/a/aa/Average_annual_growth_rate_of_expenditure_on_social_protection_benefits%2C_2008-2017_%28%25%29_SPS19.png

Figure 4.2 -Spending on disability benefits as % of GDP in EU in 2017



Source: Eurostat

Figure 4.3 -Spending on disability benefits as % of total social protection spending in EU in 2017



Note: Latest available data. *Source: Eurostat.*

Table 4.1 - Expenditure on social protection benefits in EU in 2017 by function

	Old age and survivors		Sickness / Health Care		Disability		Family / Children		Unemployment		Housing and Social Inclusion	
	(% of social protection benefits)	(% relative to GDP)	(% of social protection benefits)	(% relative to GDP)	(% of social protection benefits)	(% relative to GDP)	(% of social protection benefits)	(% relative to GDP)	(% of social protection benefits)	(% relative to GDP)	(% of social protection benefits)	(% relative to GDP)
EU-28	45.8	12.3	29.6	7.9	7.6	2.0	8.7	2.3	4.4	1.2	4.0	1.1
Euro area (EA-19)	46.1	12.8	29.5	8.2	7.4	2.0	8.3	2.3	5.2	1.4	3.5	1.0
Belgium	46.5	12.6	26.9	7.3	8.7	2.4	7.6	2.1	6.9	1.9	3.4	0.9
Bulgaria	49.3	8.1	28.2	4.6	7.5	1.2	10.7	1.8	3.1	0.5	1.2	0.2
Czechia	47.2	8.5	32.7	5.9	6.4	1.1	8.8	1.6	2.6	0.5	2.4	0.4
Denmark	39.2	12.1	21.3	6.6	16.5	5.1	11,1	3.4	4.5	1.4	7.4	2.3
Germany	38.6	11.0	35.0	10.0	8.5	2.4	11.5	3.3	3.4	1.0	3.0	0.9
Estonia	41.7	6.6	29.9	4.7	11.6	1.8	13.1	2.1	2.7	0.4	1.0	0.1
Ireland	33.6	4.8	39.2	5.6	5.6	0.8	8.5	1.2	8.8	1.3	4.3	0.6
Greece	62.8	15.6	20.3	5.1	5.9	1.5	5.7	1.4	3.7	0.9	1.6	0.4
Spain	51.6	11.9	26.7	6.1	7.2	1.6	5.4	1.2	7.7	1.8	1.4	0.3
France	45.5	14.4	28.7	9.1	6.5	2.0	7.6	2.4	6.1	1.9	5.7	1.8
Croatia	43.5	8.9	33.7	6.9	10.7	2.2	8.6	1.8	2.1	0.4	1.4	0.3
Italy	57.8	16.2	23.1	6.5	5.8	1.6	6.3	1.8	5.8	1.6	1.2	0.3
Cyprus	55.9	10.1	18.3	3.3	4.4	0.8	6.7	1.2	5.6	1.0	9.1	1.6
Latvia	49.0	7.2	25.4	3.7	9.1	1.3	10.9	1.6	4.5	0.7	1.2	0.2
Lithuania	45.2	6.5	31.3	4.5	9.3	1.3	8.3	1.2	3.8	0.5	2.1	0.3
Luxemburg	39.6	8.5	24.9	5.4	10.8	2.3	15.3	3.3	5.4	1.2	4.0	0.9
Hungary	49.7	9.0	27.7	5.0	6.0	1.1	12.1	2.2	1.7	0.3	2.8	0.5
Malta	52.6	8.4	34.3	5.5	3.5	0.6	5.5	0.9	2.2	0.4	1.9	0.3
Netherlands	42.1	11.6	33.7	9.3	9.2	2.5	4.2	1.2	4.0	1.1	6.9	1.9
Austria	50.0	14.3	26.0	7.4	6.2	1.8	9.5	2.7	5.8	1.6	2.5	0.7
Poland	54.1	10.6	22.8	4.5	7.3	1.4	13.4	2.6	1.6	0.3	0.8	0.2
Portugal	58.3	13.7	25.5	6.0	7.1	1.7	4.9	1.2	3.2	0.8	0.9	0.2
Romania	56.3	7.9	28.0	3.9	6.5	0.9	7.7	1.1	0.5	0.1	1.1	0.2
Slovenia	47.4	10.5	34.0	7.6	4.8	1.1	8.3	1.8	2.4	0.5	3.1	0.7
Slovakia	45.8	8.1	31.7	5.6	8.8	1.6	9.1	1.6	2.9	0.5	1.7	0.3
Finland	45.1	13.6	22.5	6.8	9.6	2.9	9.8	2.9	7.3	2.2	5.8	1.7
Sweden	44.2	12.5	26.1	7.4	10.9	3.1	10.2	2.9	3.5	1.0	5.2	1.5
United Kingdom	43.4	11.3	32.6	8.5	6.7	1.7	9.4	2.5	1.3	0.3	6.7	1.7

Source: Eurostat (online data code: spr_exp_sum)

4.2 An overview of key government programs to support persons with disabilities

In this section we provide description and some discussion on public funded programs to support persons with disabilities. Where possible, the number of beneficiaries and public expenditure is presented as well.

4.2.1 State social insurance

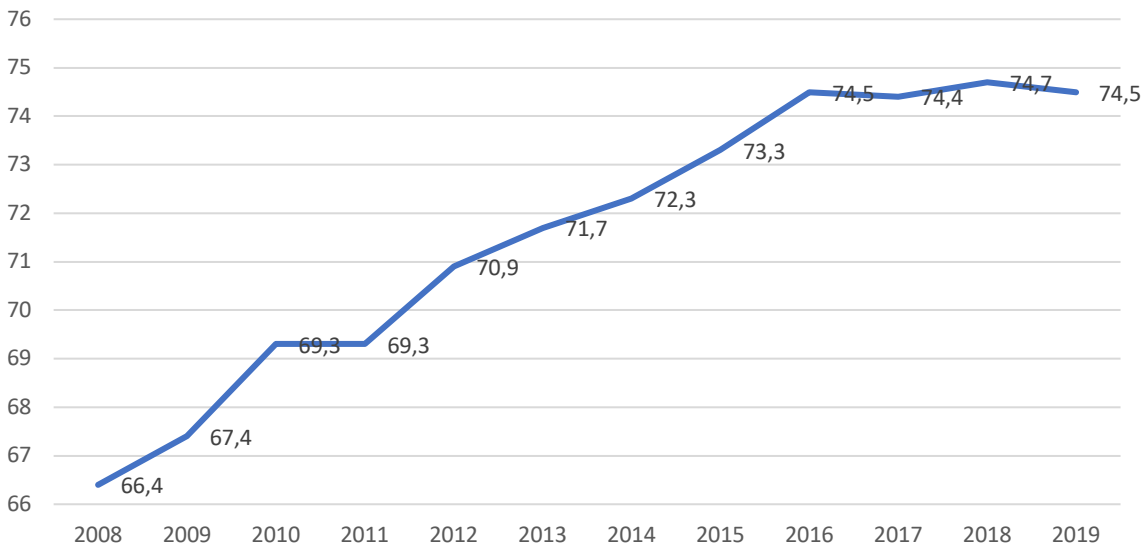
(i) State social insurance disability pension

Eligibility and administrative provisions: Disability pension is regulated by "*The Law on State Pensions*".[108] It is one of the benefits provided by a mandatory, contributory social insurance system. To qualify for a disability pension, a person residing in Latvia should be below the statutory retirement age for old-age pension, certified as a person with disability SMC, have at least three years of social insurance contribution record, reside in Latvia and not be receiving an old-age pension from another country.

The disability pension is administered by SSIA. After having been certified as a person with disability by SMC, she or he must submit an application and other relevant documents to any division of SSIA. The SMC electronically transfers to SSIA information on its decision on disability.

A disability pension is granted for a period during which a disability certification has been granted, but for no longer than until a person reaches mandatory retirement age at which point s/he begins to receive an old-age pension. Disability pension is paid out monthly and may be received at the place of residence (a delivery fee is currently EUR 2.39[109]): alternatively, it can be wired to a person's bank or a postal system account.

Figure 4.4 -Number of disability pensioners 2008-2019



Source: Latvia Central Statistical Bureau.

Should the severity of the disability change, the disability pension is recalculated.

The SSIA decision may be appealed to the SSIA Director within one month from the date of entry into force. The decision of the Director may be appealed to the court within one month from the date of its entry into force.

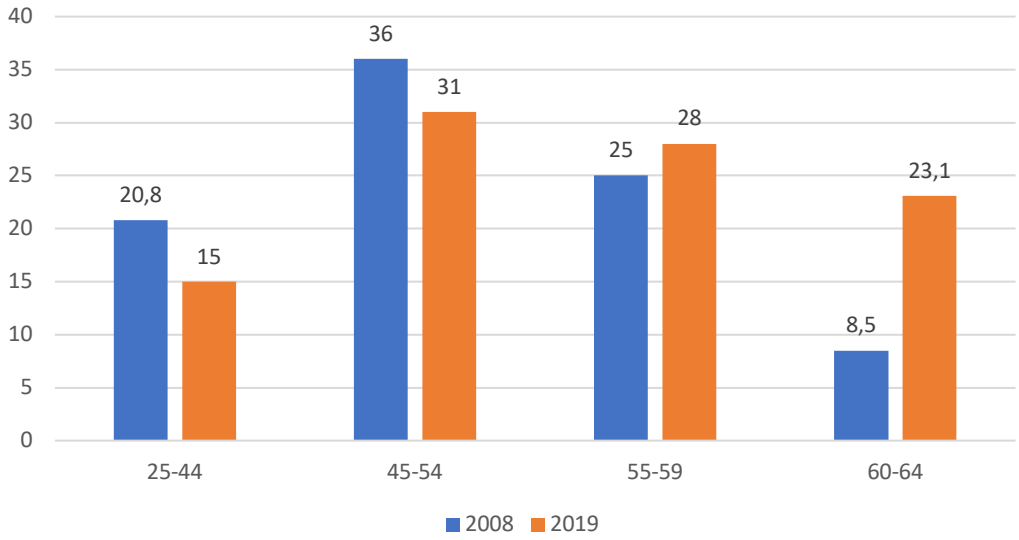
Beneficiaries: Between 2008 and 2019, the number of persons receiving disability pension increased by 12.2 percent – from 66,400 to 74,500 people (Figure 4.4). The share of disability pensioners in the

[108] Available at: https://likumi.lv/ta/id/38048-par-valsts-pensijam
[109] A standard delivery fee charged for all social benefits deliver at the residential address.

total number of pensioners increased as well: from 11.8 to 13.4 percent. Overall, about two thirds of working age persons with disabilities were receiving this benefit.

Looking at the age composition of disability pension recipients, there has been a significant change between 2008 and 2019 (Figure 4.5), likely reflecting the increase in retirement age. In 2008, 36.0 percent of the recipients were 45-54 years of age, followed by 28.0 percent in the 55-59 age cohort and 20.8 percent in the 25-44 years age cohort. In 2019, almost one fourth of the recipients were in the 60-64 age cohort.

Figure 4.5 -Disability pension recipients by age 2008 and 2019



Source: Authors based on data from the Latvia Central Statistical Bureau.

Disability pensions amounts: For persons assigned a Group III disability, disability pension is equal to the amount of the state social security benefit for persons with disability, which in January 2020 was EUR 80.0.[110] For persons with disabilities since childhood, this amount was EUR 122.7 (Table 4.2).

Disability pensions for a Group I disability and a Group II disability are calculated following a formula[111] that takes into account the severity of disability, the average insurance contribution wage of the insured person for any 36 consecutive months during the last five years preceding the granting of the disability pension, and the individual's overall length of insurance relative to the maximum possible length of insurance up to the mandatory retirement age multiplied by 0.1. The pension is then calculated as 0.45 times (for Group I disability) or 0.40 times (for Group II disability) times the insured's average earnings in any 36 consecutive months in the last five years plus the insured's average earnings multiplied by the ratio of actual contribution years to the total possible number of years of coverage from age 15 to retirement multiplied by 0.1 (the second portion is almost negligible).

Essentially, for Group I, disability pension is equal to 45.0 percent of the person's average wage on which social insurance contributions were paid over a consecutive period of three years, out of the last five years prior to disability. In the case of Group II disability, the benefit replacement rate is 40.0 percent. Hence, other variables being equal, the difference in pension between Group I and Group II disability would only be 12.5 percent – a very small difference. It is not clear how the coefficients 0.45

[110] We could not find the methodology for determining the state social security benefit or for coefficients applied to it determine the minimum disability pension for Group I and Group II disability.
[111] Ibid, s.16: https://likumi.lv/ta/id/38048-par-valsts-pensijam

and 0.4 were chosen: it seems that the choice reflects the budget constraints, rather than actuarial calculations.

The Law on State Pensions stipulates that the pension for Group I disability cannot be lower than 1.6 times the state social security benefit, and for the Group II disability 1.4 times the state social security benefit (Table 4.2).

Table 4.2 -The minimum amounts of disability pensions as of January 2020

Type of pension	Disability (EUR)	Disability since childhood (EUR)	Notes
Group I disability pension	128.00	196.30	Coefficient 1.6 is applied to the state social security benefit.
Group II disability pension	112.00	171.77	Coefficient 1.4 is applied to the state social security benefit.
Group III disability pension	80.00	122.69	Equal to the amount of the state social security benefit for persons with disability

Source: SISA . https://www.vsaa.gov.lv/en/services/for-seniors/disability-pension/

Using the minimum wage for 2020 (EUR 430.0 per month), the average net wage in January 2020 (EUR 813), the average old-age pension in quarter one of 2020 (EUR 363.3) and the value of the per capita minimum consumer basket of goods and services (EUR 253.0, the last calculated amount in December 2013) as benchmarks, the minimum disability pensions seem very low.

It is important to note that in Latvia, *a person receiving a disability pension is allowed to work*. This is a very good feature of disability policy compared to many other countries where the receipt of a disability pension is conditioned upon a person leaving employment. Allowing persons with disabilities receiving disability social insurance benefit to work, a major obstacle for their labor force participation is removed. Moreover, they can continue to work in their job, or similar job with the same employer while receiving a disability pension.

Compared to the minimum wage (EUR 430.0): Group III disability pension was 18.6 percent (for disability since childhood 28.5 percent); Group II minimum disability pension was 26.0 and 39.9 percent respectively and Group I minimum disability pension was 29.8 and 45.7 percent.

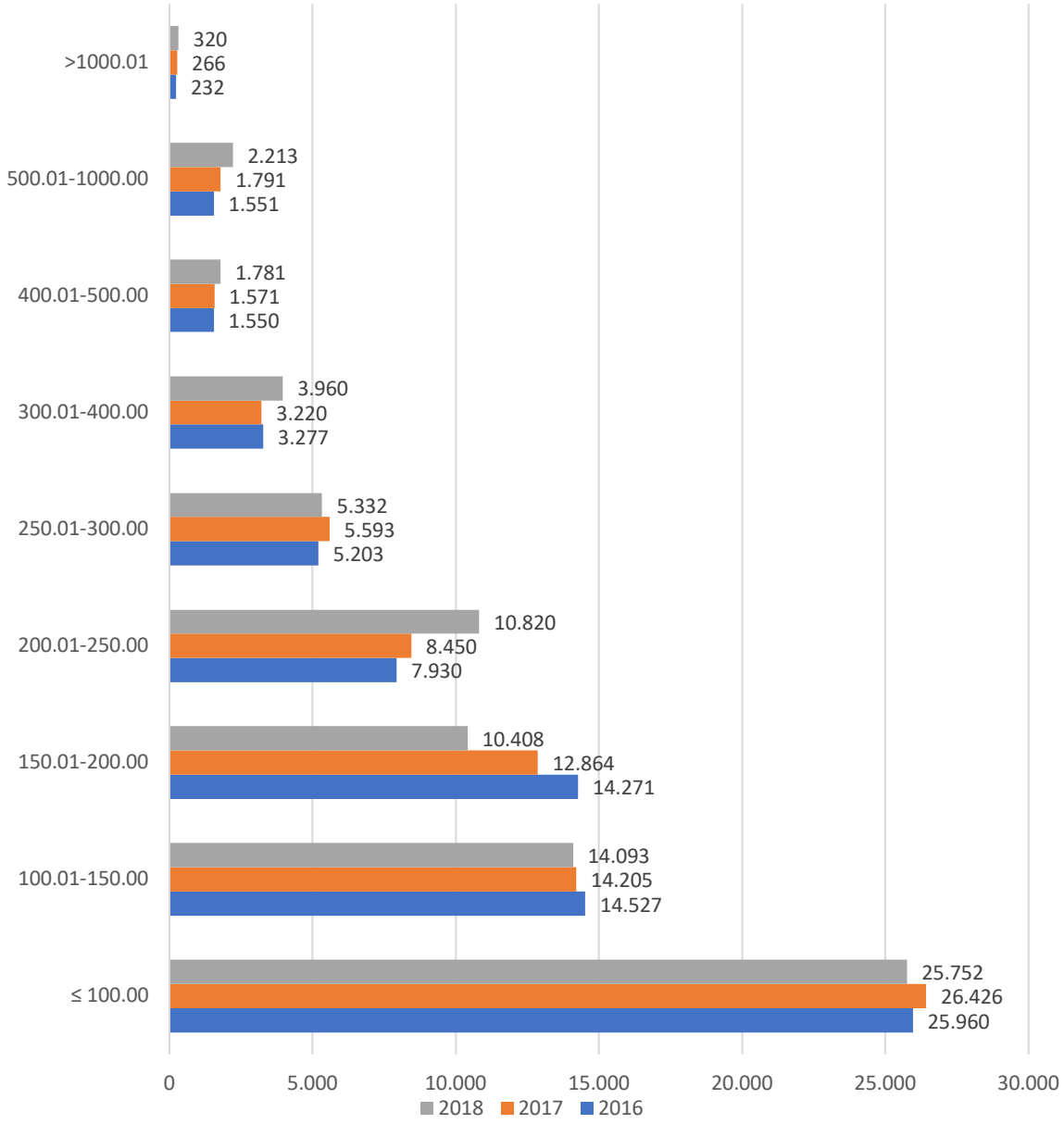
Compared to the average wage (EUR 813.0): Group III disability pension was 9.8 percent (for disability since childhood 15.0 percent); Group II minimum disability pension was 13.8 and 21.1 percent respectively and Group I minimum disability pension was 15.7 and 21.4 percent.

Compared to the average old age pension (EUR 363.3): Group III disability pension was 22.0 percent (for disability since childhood 33.4 percent); Group II minimum disability pension was 30.8 and 47.3 percent respectively and Group I minimum disability pension was 35.2 and 54.0 percent.

Compared to the minimum consumer basket of goods and services (EUR 253; calculated by MOW): Group III disability pension was 31.6 percent (for disability since childhood 48.5 percent); Group II minimum disability pension was 44.3 and 67.9 percent respectively and Group I minimum disability pension was 50.6 and 77.6 percent.

As presented in Figure 4.6, most disability pensions are very low. In 2018, most recipients – 82.0 percent - received a disability pension of EUR 250.0 per month or lower. Almost 35.0 percent received a disability pension below EUR 100.0 per month.

Figure 4.6 - Disability pension recipients by the average amount of pension 2016-2018

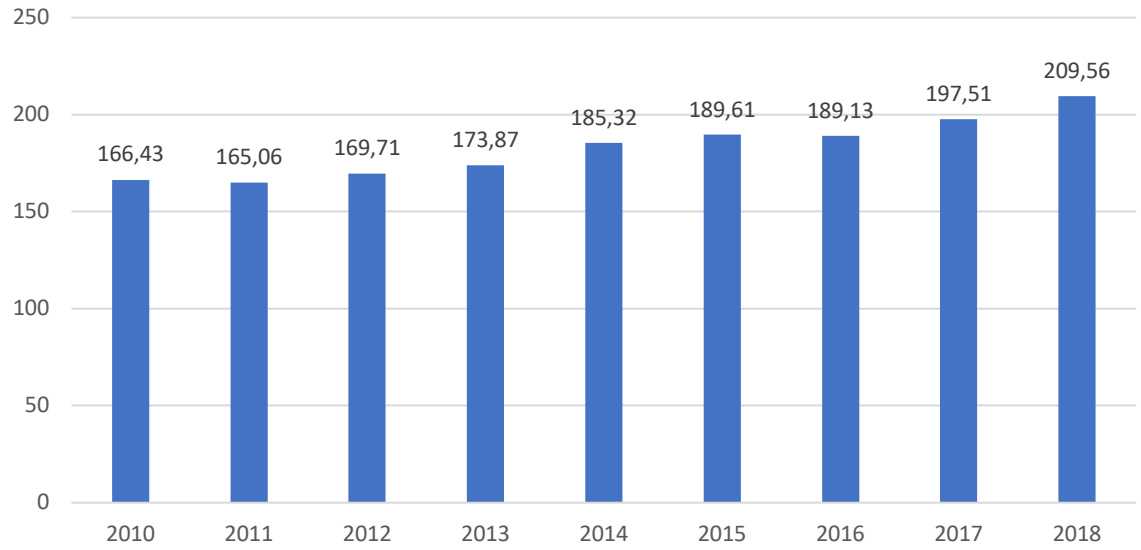


Source: Central Statistical Bureau. Number of pension recipients by average pension. Available at: http://data1.csb.gov.lv/pxweb/lv/sociala/sociala__socdr__pensijas__ikgad/SDG040.px/

Overall, as noted, disability pensions in Latvia are low and it is hard to grasp the rationale and logic behind their determination, and why there is differentiation by severity of disability.

Spending on disability pensions: Disability pensions are financed from contributions to SSIA and its budget for disability, maternity and sickness. Figure 4.7 presents nominal spending in million EUR 2010-2018.

Figure 4.7 -Spending on disability pensions 2010-2018
(in million EUR in current prices)



Source: Eurostat.

(ii) Social insurance disability benefits in cases of occupational disease/ accident at work

A person covered by mandatory social insurance who has been involved in an accident at work or whose health has deteriorated due to an occupational disease and is experiencing temporary or longer term/ permanent loss of work ability is entitled to a range of benefits including paid sick leave and medical treatment. If a person has been assessed by SMC as having disability or who has lost capacity to work, then the person is entitled to a compensation for the loss of ability to work, compensation for additional expenses due to medical treatment and rehabilitation, care service, retraining and vocational rehabilitation, purchase and repair of assistive/technical aids and compensation for transport cost to visit a doctor. The person is not required to cease employment. If a beneficiary dies, then his survivors are entitled to a survivor's pension and a funeral allowance. Compensation for the loss of capacity to work is not granted to persons who is assessed to have lost 10-24 percent of work capacity.

Social insurance disability benefits in cases of occupational disease and accident at work are regulated by The Law on Compulsory Social Insurance Regarding Accidents at Work and Occupational Diseases[112], as well as by pertinent regulation issued by the Cabinet of Ministers.[113]

This Law defines the **loss of capacity for work** as a "temporary or permanent limitation of physical or mental capacity not related to ageing, caused by an accident at work or an accident while on the way to or from work in a means of transport owned by the employer, or by an occupational disease, which impedes the integration of the person into society, fully or partially restricts her/ his capacity to work and to take care of oneself".[114]

[112] The Law on Compulsory Social Insurance Regarding Accidents at Work and Occupational Diseases 1995. Riga: Saeima. https://likumi.lv/ta/id/37968-par-obligato-socialo-apdrosinasanu-pret-nelaimes-gadijumiem-darba-un-arodslimibam

[113] Cabinet regulation: *Procedures for Granting and Calculation of Insurance Compensation from the Compulsory Social Insurance Against Accidents at Work and Occupational Diseases, 1999*. SI 1999/50. Riga: Cabinet of Ministers. Available at: https://likumi.lv/doc.php?id=21903

[114] Ibid.

To qualify for benefits under the accident at work or occupational disease social insurance, a person should have insurance coverage for at least 3 years since January 1, 1997. The person must also be able to formally prove that she/he had an accident at work or while going to or from work in a means of transport owned by the employer: in the case of an occupational disease, it must be proven that the disease resulted in a temporary incapacity for work, a partial or complete loss of capacity for work, or the death of the insured person.

The benefits are administered by SSIA, are part of the overall social insurance package, and funded from the same source of funding as disability pension described above (the "maternity, sickness and disability benefits" portion of the social insurance budget).

***Benefits calculation*:**

(i) *Sickness benefit*: 0.8*(average insurance contribution wage per day*number of calendar days of work incapacity); in other words, the replacement rate is 80.0 percent.

(ii) *Compensation for the loss of ability to work* is a monthly payment determined as percentage of the person's average wage on which social insurance contributions were paid during the 12-month period prior to the loss of ability to work:
   a) 80 percent - if the loss of ability to work is 100 percent;
   b) Up to 80 per cent - if the loss of ability to work is 80-99 percent;
   c) Up to 65 percent - if the loss of ability to work is 50 to 79 percent;
   d) Up to 50 per cent - if the loss of ability to work is 25 to 49 per cent (35.0 percent for the loss of ability to work 25-29.0 percent).

(iii) *Compensation for additional expenses* for medical treatment and rehabilitation is calculated on the basis of the actual cost as evidenced by receipts. The total amount of compensation is capped at twenty-five times the state social security benefit.

(iv) *Funeral allowance* is equal to one average monthly insurance contribution wage of deceased the insured person. If a deceased person was receiving the compensation for the loss of capacity to work, the funeral allowance is equal to two monthly compensation payments.

(v) *Survivor's benefit* depends on the average monthly insurance contribution wage of the insured person; a person who will receive the benefit (a spouse or parents of the deceased); number of children under 18 years of age and their status (e.g. whether a deceased was a single parent) and other conditions. The benefit should not exceed 80.0 percent of the average monthly insurance contribution wage of the insured person and should not be lower than the state social security benefit. The benefit per child should not be lower than the minimum determined by the Cabinet of Ministers.

Duration of benefits: A sickness benefit is granted for the established period of sickness. In case of an accident at work, the first 10 days of incapacity are paid by the employer; the rest is paid by SSIA. If the sickness leave is due to an occupational disease, SSIA pays from the day of the temporary incapacity for work when the Medical Commission of the Centre for Occupational and Radiation Medicine of the P. Stradins Clinical University Hospital, Ltd. has determined the occupational disease. Compensation for the incapacity for work is granted for the period determined by SMC. Compensation for additional expenses for medical treatment is reimbursed as a lump-sum, post factum. For the renewal/continuation of the incapacity for work benefit, the SMC decision is required.

Administrative process concerning the compensation: The applicant should apply to SSIA, a conclusion of the Medical Commission of the Centre of Occupational and Radiation Medicine of the P. Stradins Clinical University Hospital, Ltd. on the occupational disease and other documents to substantiate the cost. The State Labor Inspectorate electronically send to SSIA information regarding the accident at work. SMC determines disability and the loss of ability to work in percentage and transmits electronically the information regarding the decision on disability to SSIA. SSIA reviews the application

and is obliged to decide within month after having received the application and the documents. The SSIA's decision can be appealed following general administrative procedures for appeals.

Figure 4.8 - Sickness benefit – recipients and average benefit per case (EUR)

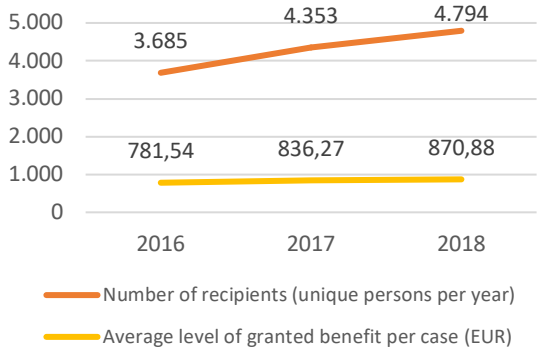
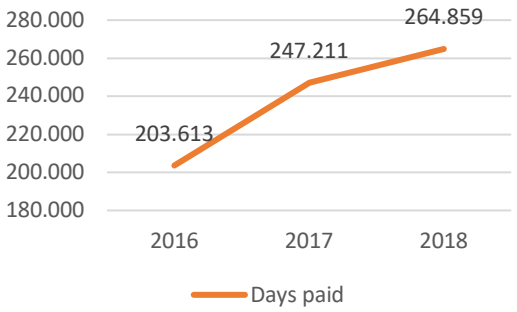


Figure 4.9 - Total number of days paid

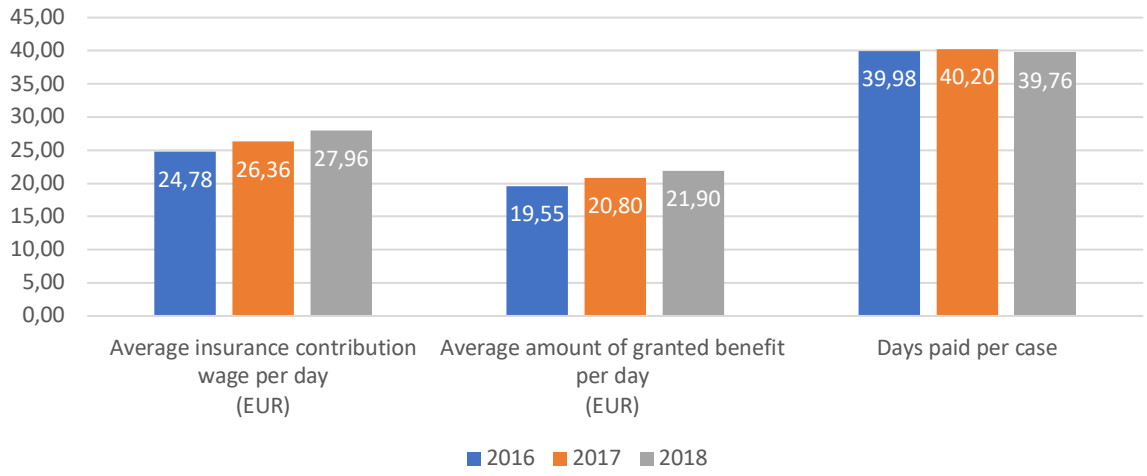


Source: SSIA

Figures 4.8 and 4.9 present recent data on the sickness benefit in cases of an occupational disease or accident at work. In only two years, the number of persons who went on a sick leave due to an accident at work or occupational disease increased from 3,685 (2016) to 4,794 (2018) or by 30.0 percent. The number of days of sick leave paid increased from 203,613 days to 264,859 days per year (30.0 percent as well.). The average sick leave benefit increased by 11.5 percent. This almost explosive increase in the sick leave due to accidents at work or occupational disease is something MOW and SSIA should look at to understand the reasons for the increase. They should also look to strengthen policies to ensure health and safety at the workplace.

Figure 4.10 presents some more data on the sick leave benefits: the average insurance contribution wage per day; the average amount of granted sick leave benefit per day and the average number of days of sick leave paid per case.

Figure 4.10 -Sickness benefit in the case of accidents/ occupational disease 2016-2018



Source: SSIA

Table 4.3 presents the number of the recipients of the compensation for the loss of ability to work 2016-2019. The statistics indicates fast growth: 22.0 percent since 2016. This is something MOW may wish to look at, focusing on prevention and workers safety and possibly increasing contributions and obligations of higher risk employers.

Table 4.3 -Compensation for the loss of ability to work due to work accidents and occupational diseases: beneficiaries

Year	Number of beneficiaries
I-IX 2019	10,424
2018	9,987
2017	8,973
2016	8,541

Source: SSIA. Data on request.

The insurance benefit package under the *Law on Compulsory Social Insurance Regarding Accidents at Work and Occupational Diseases* also includes:

- Additional compensation for medical treatment not included in the health care basic benefit package, purchase of medical products, including medicines, co-pays, medical rehabilitation and travel expenses to visit medical facility.
- Additional compensation for cost of social rehabilitation, prosthetics, purchase and repair of technical aids, payment for accompanying person and vocational rehabilitation.
- Employment support, including requalification.

The compensation is determined based on the documented actual cost. The total amount of compensation for treatment and rehabilitation costs is capped at twenty-five times the state social security benefit (see Table 4.4 on beneficiaries and spending).

The eligibility requirements, administrative process, duration, methods of payment, and grievance redress are the same as for other benefits under this insurance (see above). The benefits are funded by the SSIA – Special Accident Budget.

Table 4.4 -Compulsory social insurance in case of accidents at work and occupational diseases: additional compensation: beneficiaries and spending

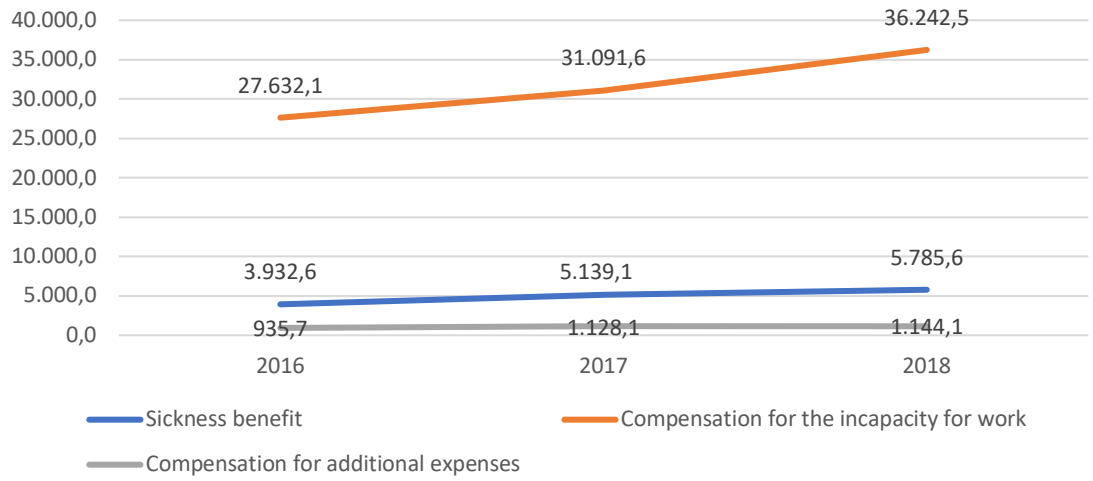
Year	Beneficiaries	Spending (EUR million)
I - IX 2019	5,571	0,1038
2018	6,206	1,388
2017	6,030	1,415
2016	5,183	1,128

Source: SSIA. Data on request.

Figure 4.11 presents statistics on spending for sickness benefit, compensation for the incapacity to work and compensation for additional expenses over 2016-2019, in cases of occupational disease or accident at work. All three expenditure items surged: expenditure on sickness benefit jumped by 47.1 percent; compensation for the incapacity for work by 31.2 percent and compensation for additional expenses by 22.3 percent. The total spending of SSIA on these three benefits increased from EUR 32.5

million to EUR 43.2 million or 33.0 percent. The growth is such that it deserves a thorough review by MOW and SSIA.

Figure 4.11 -Total expenditures for benefits related to accident at work or occupational disease



Source: SSIA

The purpose of mandatory social insurance is to mitigate the risk and impact of the loss of income due to old age, disability and the loss of a breadwinner (survivorship). Theoretically, the case for disability insurance is clear – it is an event with low probability of happening, but with huge adverse impact when it happens. It is therefore irrelevant what the cause of disability is.

While social insurance is mandatory for all employees and their employers, without earmarking of social insurance contributions, Latvia has chosen to differentiate benefits between disability due to occupational disease or accident at work and disability dues to general illness and accidents. They are assessed for disability using different criteria (see Chapter Three). The latter group has lower benefits than the former, although there is no difference in the social insurance contribution rate, effectively resulting in the group with lower benefits subsidizing the other.

Suppose, for example, similar employees, working for the same employer. Normally, both of them travel to and from work in a van owned by the employer. One morning, one of them travels in her/his own car. Both are involved in the same traffic accident and suffer the same injury. The one who has travelled in the employer's van will be assessed by SMC for the loss of capacity to work, awarded a compensation for the loss of work ability; and her/his wage replacement coefficient will be, say, 80.0 percent. The other will be assessed for disability, will be awarded a disability pension, and her/his his wage replacement rate will be about 45.0 percent.

This is an unfair situation that MOW should review, with a view to unifying disability assessment criteria and equalizing the social insurance benefits between the two groups. Any additional benefits due to accidents at work or occupational disease should be funded from a separately earmarked contribution paid by employers, including a lump sum compensation for the loss of body parts or body functions. Another option would be to separate accident and occupational disease insurance from general social insurance, with earmarked contribution rates differentiated by the risk of insurance events and paid by employers.

4.2.2 State social allowances - general budget funded disability benefits

i. An overview

The types of social benefits provided by the state, target populations. eligibility requirements, and administrative procedures to award and disburse them, are all regulated by *The Law on State Social Allowances.*[115] *The Disability Law*[116] and *The Law on Social Protection of Participants Involved in the Mitigation of the Consequences of the Chernobyl Nuclear Power Station Accident and Persons Who Have Suffered due to It*[117] and associated regulations of the Cabinet of Ministers and SSIA. The state social allowances are administered by SSIA.

The Law on State Social Allowances states that Latvian citizens, non-citizens, aliens and stateless persons to whom a personal identity number has been issued and who reside permanently on the territory of Latvia have the right to receive state social benefits. For the receipt of child benefits, a child or an adopted child must have a personal identity number. Persons who have only received a temporary residence permit in Latvia do not have the right to state social benefits. The payment of benefits is suspended for a period of time during which a beneficiary is fully supported by the state (hospitalization, imprisonment, institutionalization, etc.).

To receive any of the state benefits, a person must apply to SSIA (in person, by post or electronically) or submit an application in one of the customer services centres of the state or local governments which have the cooperation agreements with SSIA. Another option is to fill in an E-application through the Joint State Service Portal www.latvija.lv. The benefit ought to be requested within six months from the date a person has become entitled to it. If the term is overdue, but the benefit is granted by SSIA, the benefit will be paid only for the previous six months from the date of application.

The Law also lays out uniform procedures for decision-making by SSIA employees, as well as procedures to contest and appeal SSIA decisions. The general rule is that administrative acts issued by an official of SSIA may be appealed to the director of SSIA. The administrative acts issued by the SSIA director, as well as decisions regarding appealed administrative acts may be appealed to the court in accordance with the procedures specified in *The Administrative Procedure Law*.

The Law on State Social Allowances, in addition to general state social benefits, specifies the following benefits for persons with disabilities:

- Allowance for a child with disabilities;
- Care benefit for disabled child;
- State social security benefit;
- Care benefit for a person with disability;
- Transport allowance for disabled persons with restricted mobility.

The Disability Law provides for assistant services for persons with Group I visual disability. *The Law on Social Protection of Participants Involved in the Mitigation of the Consequences of the Chernobyl Nuclear Power Station Accident and Persons Who Have Suffered due to It* provides for an allowance to the participants and compensation to the participants with determined incapacity for work of 10 –

[115] The Law on State Social Allowances 2002. Riga: Saeima. Available at: https://likumi.lv/ta/id/68483-valsts-socialo-pabalstu-likums.
[116] The Disability Law 2010. https://likumi.lv/ta/id/211494-invaliditates-likums
[117] The Law is available at: https://likumi.lv/doc.php?mode=DOC&id=17962

25.0 percent. Most of these benefits are briefly presented in the next sections (see also Annex 8 for details).

There were, in 2018, in the SSIA database, 196,028 individuals formally certified as persons with disabilities. According to SSIA, they were receiving in total 306,097 benefits, or about 1.6 benefits per person: 58.0 of persons with disabilities received only one benefit; 39.0 percent received 2 or 3 benefits. About 3.0 percent received more than 3 benefits. The data base registers each payment of periodic benefits (e.g. transport benefit that is paid out twice per year) as a single benefit, so the same benefit may be counted as two benefits (Table 4.5).

Table 4.5 - State disability benefits received by each person certified as disabled, distribution in % in 2018

	N	%
None	2,519	1,29
1	113,977	58,14
2	54,585	27,85
3	21,744	11,09
4	2,542	1,30
5	469	0,24
6	140	0,07
7	41	0,02
8	7	0,00
9	3	0,00
10	1	0,00
Total	196,028	100

Source: SSIA

Table 4.6 presents SSIA statistics on beneficiaries and public spending on key disability programs administered by it and their respective shares in GDP in 2018. Data is reported only on persons with temporary (on sick leave) and permanent disability, registered in the SSIA data base. The table includes persons with disabilities who are receiving an old age pension (88,448 persons or 29.0 percent of persons with disabilities in 2018) and persons who have received sickness benefit (23,140 persons). In total, the spending constituted 1.99 percent of GDP. However, since persons with disabilities receiving an old age pension formally count as old-age pensioners and their pension is funded from the old-age social insurance budget, public spending on disability benefits through SSIA was only 1.0 percent of GDP, half of which was spent on disability pensions, followed by special care benefit (0.14 percent of GDP); benefits in case of accident at work and occupational disease (0.11 percent of GDP); and state social security benefit (0.08 percent of GDP).

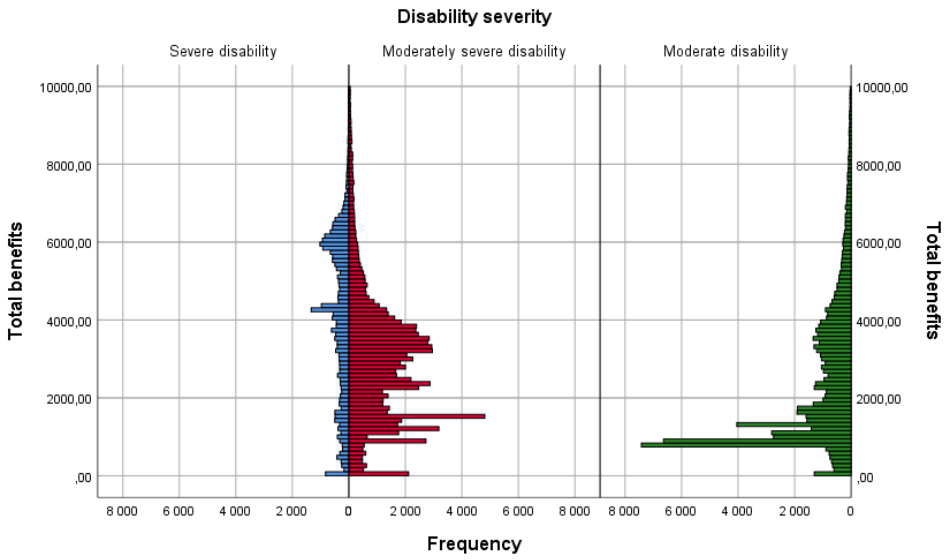
Table 4.6 -Beneficiaries and public spending
on key disability programs administered by SSIA in 2018

	N	%	EUR	% of GDP*
Persons with disabilities over mandatory retirement age	88,448	28.90	288,419,562	0.98
Early retirement pensioners with disability	842	0.28	2,889,616.8	0.01
Disability pension	86,253	28.18	132,501,462	0.45
Survivor's disability pensions	3,387	1.11	67,84,626.2	0.02
State social security benefit (i.e. for those not eligible to receive disability pension)	19,582	6.40	22,906,616	0.08
Compensation for the work capacity loss due to an accident at work or an occupational disease	10,767	3.52	32,821,029	0.11
Additional compensation due to an accident at work or an occupational disease	5,155	1.68	1,079,705.3	0.00
State special care benefit	19,969	6.52	40,394,035	0.14
Transport compensation	30,578	9.99	4,402,058.9	0.01
Benefits to participants in the Chernobyl NPS accident mitigation	3,309	1.08	10,972,069	0.04
Unemployment benefit	8,229	2.69	8,600,348.8	0.03
Sickness benefit	23,140	7.56	16,498,271	0.06
Benefit for an assistant to visually impaired person	2,451	0.80	1,905,694.8	0.01
No benefits	3,981	1.30	0.00	0.00
Total	306,091		588,703,943	1.99

Source: SSIA. *Notes: *Gross domestic product in 2018 was EUR 29,523,7 million. Central Statistical Bureau.*

Distribution of benefits by severity of disability is shown in Figure 4.12, which indicates that persons with severe disability were receiving higher benefits. This is expected as the laws mandate higher benefits for persons with severe disabilities.

Figure 4.12 -SSIA – distribution of disability benefits recipients by annual benefit amount and severity of disability 2018*



**1,475 cases whose annual benefits exceeded EUR 10,000 were excluded.*

Tables 4.7 presents statistics on the median annual and monthly amount of benefits received by persons with disabilities registered in the SSIA register in 2018 at the time of disability assessment. It should be noted that data for persons above retirement age may be misleading, because persons with disabilities start counting as old age pensioners as soon as they reach mandatory retirement age. They also begin receiving an old-age pension, determined based on their individual working record and contributions. This switch explains significant differences in the median benefits shown in Table 4.7, across age groups and particularly for severe and moderate disability. Overall, however, the benefits are low across the board.

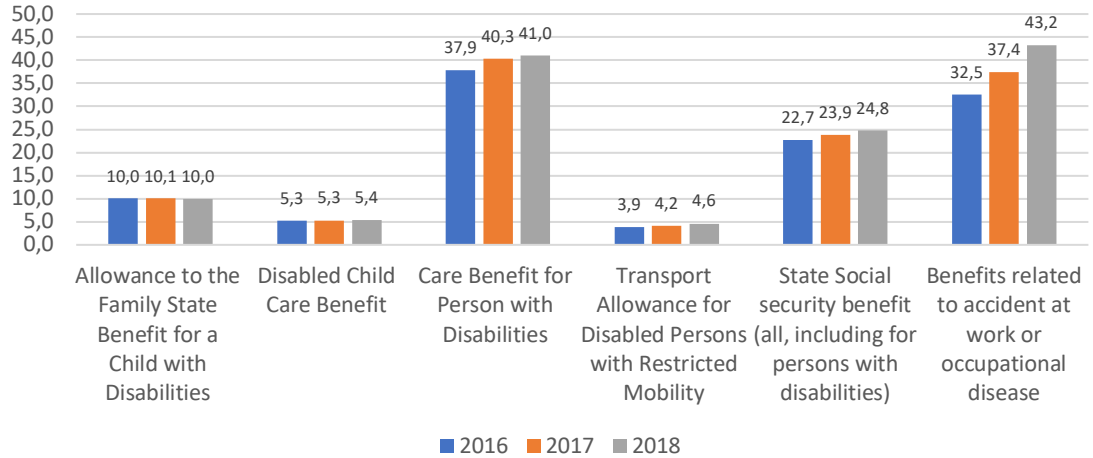
Table 4.7 -Median annual and monthly benefit received from SSIA per person with disabilities in 2018 (EUR)

	Very severe disability	Severe disability	Moderate disability
Annual			
Total	4226.04	2947.68	1810.44
Disability since childhood	4226.04	2155.76	1499.61
Disability acquired during working age	3517.76	2370.09	1252.14
Elderly (above retirement age)	4584.15	3557.78	3802.49
Monthly			
Total	352.2	245.6	150.9
Disability since childhood	352.2	179.6	125.0
Disability acquired during working age	293.1	197.5	104.3
Elderly (above retirement age)	382.0	296.5	316.9

Source: SSIA.

According to SSIA, between 2016 and 2018, public spending on social benefits to persons with disabilities increased by 7.6 percent in nominal terms. Within this period, the change in expenditures by type of benefits varies widely: 32.8 percent for benefits related to accident at work and occupational disease; 2.9 percent for disabled child care benefit; 8.2 percent for care benefit for persons with disabilities, 9.4 percent for state social security benefit; 18.0 percent for transport allowance for disabled persons with restricted mobility. In contrast, expenditure on the allowance for a child with disability decreased by 0.9 percent (Figure 4.13).

Figure 4.13 - Public expenditures on key state benefits to persons with disabilities 2016-2018 (EUR million)



Source: SSIA

ii. Allowance for a child with disabilities

This monthly benefit in cash is regulated by *The Law on State Social Allowances* and pertinent regulation of the Cabinet of Ministers.[118] Its purpose is to support families raising a child with a disability. In addition to general eligibility requirements to receive state social benefits, the child should be certified as having a disability by SMC. The allowance is granted for the established period of disability until the day when the child with disability reaches 18 years of age, as long as the child is (re)assessed as having a disability by SMC. The information on the decision is then electronically transmitted from SMC to SSIA. The benefit is financed by the state budget and administered by SSIA. SSIA reviews the application for this allowance submitted by a parent or guardian of a disabled child and is obliged to decide within 10 days after the application has been received. The decision can be appealed following general administrative procedures.

At the beginning of 2020, the allowance was EUR 106.72. Number of beneficiaries and expenditure is presented in Table 4.8.

Table 4.8 - State allowance for a child with disabilities: number of beneficiaries[119] and spending[120] 2016-2019

Year	Number of beneficiaries	Expenditure (000 EUR)
August 2019	7,784	7,545 (Jan-Sept 2019)
2018	7,723	9,953
2017	7,746	10,055
2016	7,769	10,047

Source: SSIA (webpage and data on request).

iii. Allowance for care of disabled child

This monthly benefit in cash is regulated by *The Law on State Social Allowances* and pertinent regulation of the Cabinet of Ministers.[121] The purpose of the benefit is to support families raising a child with a disability. To receive this benefit, in addition to general eligibility requirements to receive state social benefits and a child having been certified as having a disability by SMC, it is also required that SMC issues an opinion that the child is in need of special care. The allowance is granted for the established period of disability until the day when the child with disability reaches 18 years of age, as long as the child is (re)assessed as having a disability and is in need of special care by SMC, after which the information on the decision is electronically transmitted from SMC to SSIA. The benefit is financed by the state budget and administered by SSIA. SSIA reviews the application for this allowance submitted by a parent or guardian of a disabled child and is obliged to decide within a month after the application has been received. The decision can be appealed following general administrative procedures.

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[118] *The Law on State Social Allowances 2002*. (s.6). https://likumi.lv/ta/id/68483-valsts-socialo-pabalstu-likums. Cabinet Regulation: *The Regulations Regarding the Amount of the Family State Benefit and the Supplement to the Family State Benefit for a Disabled Child, the Review Procedure Thereof, and the Procedures for Granting and Payment of the Benefit and Supplement*, 2009. SI 2009/1517. Riga: Cabinet of Ministers. Available at: https://likumi.lv/doc.php?id=202676.

[119] State Social Insurance Agency. "Budget and Statistics". November 2019. https://www.vsaa.gov.lv/par-vsaa/parmums/

[120] State Social Insurance Agency. Data on request.

[121] *The Law on State Social Allowances 2002*. (s.6). https://likumi.lv/ta/id/68483-valsts-socialo-pabalstu-likums. Cabinet Regulation: *The Regulations Regarding the Amount of the Disabled Child Care Benefit, the Procedures for the Review Thereof, and the Procedures for Granting and Payment of the Benefit, 2009. SI 2009/1607*. Riga: Cabinet of Ministers. Available at: https://likumi.lv/doc.php?id=202852&from=off

As of July 1, 2019, the allowance has been EUR 313.43 (previously EUR 213.43). Number of beneficiaries and expenditure is presented in Table 4.9.

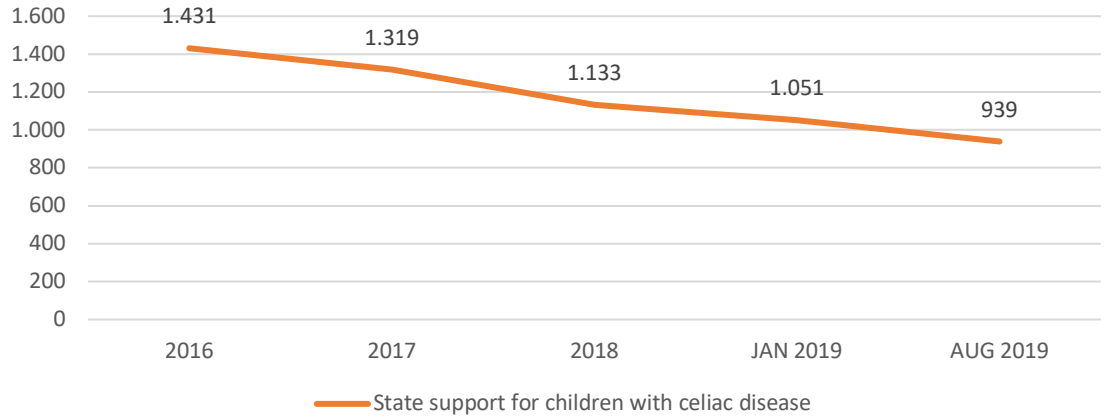
Table 4.9 -State allowance for care of a disabled child: number of beneficiaries[122], refused applications[123] and spending[124] 2016-2019

Year	Number of beneficiaries	Refused applications	Expenditure (000 EUR)
August 2019	2,273	50 (Jan-Sept 2019)	5,038 (Jan-Sept 2019)
2018	2,038	49	5,417
2017	2,053	44	5,303
2016	2,006	32	5,262

Source: SSIA (webpage and data on request).

The state also provides support for children with celiac disease, if a child is under 18 years of age (up to 24 if in education). It is not related to disability but granted based on diagnosis alone. The benefit amount is EUR 106.72 per month. The procedures for claiming, granting, disbursing and discontinuing the benefit are similar to those in the case of the allowance for a child with disability. Only in the case of celiac disease it is necessary to have a written statement by a certified gastroenterologist indicating a diagnosis; and in this case a period of re-examination must not exceed two years from the date of issue of the statement. SMC is not involved. The number of beneficiaries is small, and it has been declining (Figure 4.14).

Figure 4.14 -Number of recipients of state allowance to children with celiac disease



Source: SSIA

iv. State social security benefit

This monthly benefit in cash is regulated by *The Law on State Social Allowances*[125] and pertinent regulation of the Cabinet of Ministers. The purpose of the benefit is to support income of individuals

[122] SSIA. "Budget and Statistics". November 2019. https://www.vsaa.gov.lv/par-vsaa/parmums/
[123] SSIA. Data on request.
[124] SSIA. Data on request.
[125] Ibid. (s.13). https://likumi.lv/ta/id/68483-valsts-socialo-pabalstu-likums. Cabinet Regulations: *Regulations Regarding the Amount of the State Social Security Benefit and Funeral Benefit, Procedures for the Review thereof and Procedures for the Granting and Disbursement of the Benefits, 2009. SI 2009/1605*. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/202850-noteikumi-par-valsts-sociala-nodrosinajuma-pabalsta-un-apbedisanas-pabalsta-apmeru-ta-parskatisanas-kartibu-un-pabalstu-pieskirsanas-un-izmaksas-kartibu

who need additional income support from the state. In the case of persons with disabilities, it is targeted to persons with disabilities who do not have the right to receive the state social insurance disability pension (except when a person with disability receives a survivor's disability pension) or social insurance compensation for damages related to a work accident or occupational disease if a person is not employed (i.e. she or he is not considered to be an employee or self-employed in accordance with *the Law on State Social Insurance*) [...] and has been certified as person with disability and is older than 18 years of age. This benefit is granted for the established period of disability, as long as the person is (re)assessed as having a disability (the information on the decision is electronically transmitted from SMC to SSIA). The benefit is financed by the state budget and administered by SSIA. SSIA reviews the application submitted by a person with disability and is obliged to decide within a month after the application has been received. The decision can be appealed following general administrative procedures.

The amount of the state social security benefit is low. It remained unchanged (EUR 64) from 2005 until January 2020, when it was increased to EUR 80.0 per month. Some changes were made regarding the calculation of benefits for persons with disabilities since childhood (by increasing the amount of benefit in 2009[126] and by introducing coefficients in 2014 depending on the severity of the disability -- for benefits for persons with Group I disability a coefficient of 1.3 is applied and for persons with Group II disability this coefficient is 1.2.)[127]

The level of benefit at the beginning of 2020 was:

- For persons with disability since childhood with Disability Group III EUR 106.72.
- For persons with disability since childhood with Disability Group II EUR 128.06.
- For persons with disability since childhood with Disability Group I EUR 138.74.
- For persons with Disability Group I EUR 83.24.
- For persons with Disability Group II EUR 76.84.
- For persons with Disability Group III EUR 64.03.

The benefit is delivered once a month, either at the place of residence (with an applied delivery fee of EUR 2.39) or is transferred to the recipient's bank or postal system account. The payment of the benefit is terminated as stipulated by *The Law on State Benefits*, if the term of the disability has expired and the certification is not renewed, or if a person acquires the right to receive a state social insurance disability pension or a compensation for the loss of work capacity due to an accident at work or an occupational disease.

The number of beneficiaries 2016-2019 and data on expenditure is presented in Table 4.10. Table 4.11 presents beneficiary data by disability severity for all beneficiaries and separately for those who have been disabled since childhood. The numbers of beneficiaries have not changed much since 2016. Most, about two thirds of all beneficiaries are persons with disabilities since childhood.

[126] Amendment to the Cabinet Regulations of July 26, 2005 No. 561 "Regulations regarding the Amount of the State Social Security Benefit and Funeral Benefit, the Procedures for the Review thereof and the Procedures for the Granting and Disbursement of the Benefits", 2008. SI 2008/756. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/181295-grozijums-ministru-kabineta-2005-gada-26-julija-noteikumos-nr-561-noteikumi-par-valsts-sociala-nodrosinajuma-pabalsta-un-apbedi...

[127] Amendments to the Cabinet Regulations of December 22, 2009 No.1605 "Regulations regarding the Amount of the State Social Security Benefit and Funeral Benefit, the Procedures for the Review thereof and the Procedures for the Granting and Disbursement of the Benefits", 2014. SI 2014/6. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/263609-grozijumi-ministru-kabineta-2009-gada-22-decembra-noteikumos-nr-1605-noteikumi-par-valsts-sociala-nodrosinajuma-pabalsta-un-apb

Table 4.10 -State social security benefit for persons with disabilities: number of beneficiaries[128] and spending[129] 2016-2019

Year	Number of beneficiaries	Of which disabled since childhood	Expenditure (000 EUR)
August 2019	19,623	13,814	17,924 (Jan-Sept 2019)
2018	19,531	13,787	24,791
2017	19,538	13,712	23,850
2016	19,233	13,650	22,655

Source: SSIA. Data on request.

Table 4.11 -Recipients of the state social security benefit by disability group 2016-2019

Year	Disability group I			Disability group II			Disability group III		
	All	Disabled since childhood	Others	All	Disabled since childhood	Others	All	Disabled since childhood	Others
2016	3,287	2,778	509	9,608	6,518	3,090	6,338	4,354	1,984
2017	3,398	2,864	534	9,660	6,476	3,184	6,480	4,372	2,108
2018	3,456	2,950	506	9,586	6,147	3,169	6,489	4,420	2,069
JAN 2019	3,530	3,010	520	9,598	6,391	3,207	6,602	4,493	2,109
AUG 2019	3,550	3,030	520	9,562	6,357	3,205	6,511	4,427	2,084

Source: SSIA, data on request.

v. Special Care allowance for a person with disability

The allowance is regulated by *The Law on State Social Allowances*[130] and pertinent regulation of the Cabinet of Ministers. The purpose of the benefit is to support persons with disabilities in need of special care. To qualify for this allowance, in addition to having been certified as disabled, s/he must satisfy the SMC that there is a need for special care. The program targets adults with severe disability, including persons with severe disabilities since childhood.

This benefit is granted for the established period of disability and the necessity for special care. The information on the decision is electronically transmitted from SMC to SSIA. The benefit is financed by the state budget and administered by SSIA. SSIA reviews the application submitted by a person with disability and is obliged to decide within a month after the application and all required documents have been received. The decision can be appealed following general administrative procedures.

The benefit is paid out monthly. Since July 2019, for persons with disabilities since childhood it has been EUR 313.43 and for other persons with severe disability and in need of special care EUR 213.43.

[128] SSIA. Data on request.
[129] SSIA. Data on request. Data on expenditure is inclusive of all spending on social security benefits, although people with disabilities constitute a majority.
[130] Ibid. (s.12.1). Cabinet Regulations: *Regulations Regarding the Amount of an Allowance to a Disabled Person who Needs Care, Procedures for the Review of the Amount of an Allowance and Procedures for the Granting and Disbursement of an Allowance, 2009*. SI 2009/1608. https://likumi.lv/doc.php?id=202853

This was the first increase in 5 years (In 2014, the allowance for person with disabilities was EUR 142.29).[131]

Table 4.12 presents data on the special care allowance beneficiaries, declined applications and spending 2016-2019.

Table 4.12 -Special care allowance for persons with disabilities: number of beneficiaries[132], refused applications[133] and spending[134] 2016-2019

Year	Number of beneficiaries	Refused applications	Expenditure (000 EUR)
August 2019	15,330	95 (Jan-Sept 2019)	30,608 (Jan-Sept 2019)
2018	15,226	104	40,973
2017	15,044	56	40,295
2016	14,293	67	37,852

Source: SSIA (webpage and data on request).

vi. Transport allowance for disabled persons with restricted mobility

The transport allowance is regulated by *The Law on State Social Allowances*[135] and related regulation of the Cabinet of Ministers. The purpose of the benefit is to compensate for increased transport expenditures that persons with mobility limitations may experience. To qualify for this allowance, a person must have a disability or have a child with disability and, in addition to a certificate of disability, must obtain an opinion from SMC on the medical indications for a specially adjusted car or the receipt of an allowance for transport expenses. The benefit lasts as long as the eligibility requirements are met.

The benefit is financed by the state budget and administered by SSIA. SSIA reviews the application submitted by a person with disability or a disabled child by parents or guardians and SSIA is obliged to decide within a month after the application and other required documents have been received. The decision can be appealed following general administrative procedures.

The allowance is EUR 79.68 and it is paid once each six months (on average, it amounts to EUR 13.28 per month). The value of the allowance has remained unchanged since 2007.[136] A significant increase in the number of beneficiaries of 33.0 percent in just three years is observed (Table 4.13). It reflects

[131] Amendments to the Cabinet Regulations of December 22, 2009 No.1608 "Regulations Regarding the Amount of an Allowance to a Disabled Person who Needs Care, Procedures for the Review of the Amount of an Allowance and Procedures for the Granting and Disbursement of an Allowance.", 2013. SI 2013/1466. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/263211-grozijumi-ministru-kabineta-2009-gada-22-decembra-noteikumos-nr-1608-noteikumi-par-pabalsta-pieskirsanas-un-izmaksas-kartibu-in...

[132] SSIA. "Budget and Statistics". November 2019. https://www.vsaa.gov.lv/par-vsaa/parmums/

[133] SSIA. Data on request.

[134] SSIA. Data on request.

[135] Ibid. (s.12). Cabinet Regulations: *Regulations Regarding the Amount of the Allowance to Compensate Transport Expenses of Disabled Persons with Mobility Problems, the Procedure for Review Thereof, and the Procedures for Granting and Payment of the Allowance, 2009*. SI 2009/1606. Riga: Cabinet of Ministers. Available at: https://likumi.lv/doc.php?id=202851&from=off

[136] Amendments to the Cabinet Regulations of July 26 No. 2005 "Regulations regarding the Amount of an Allowance for the Compensation of Transport Expenses for Disabled Persons who have Difficulties Moving, the Procedures for the Review thereof and the Procedures for the Granting and Disbursement of the Allowance", 2006. SI 2006/517. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/138778

the increase in the number of persons for whom SMC issues a positive opinion about the need to receive this allowance.

Table 4.13 presents data on the transport allowance beneficiaries, declined applications and spending 2016-2019.

Table 4.13 -Transport allowance for persons with disabilities: number of beneficiaries[137], refused applications[138] and spending[139] 2016-2019

Year	Number of beneficiaries	Refused applications	Expenditure (000 EUR)
August 2019	29,132	119 (Jan-Sept 2019)	3,555 (Jan-Sept 2019)
2018	25,370	107	4,590
2017	24,098	61	4,166
2016	21,839	56	3,888

Source: SSIA (webpage and data on request).

vii. Benefit for Assistant services for persons with Group I Visual Disability

This is a small benefit that to some extent overlaps with the provision of services to persons with disabilities. The conditions for granting this benefit are determined by *The Disability Law* and associated Cabinet regulation;[140] it requires an SMC opinion.

It is a benefit in cash whose purpose is to support persons with Group I Visual Disability to obtain services of an assistant. To receive this benefit, a person must be certified by SMC as having Group I Visual Disability, should not be receiving assistant service in the municipality and should not be a recipient of the special care allowance (see above). The benefit is funded from the state budget and administered by SSIA. The benefit is granted for as long as a person meets the eligibility requirements. SSIA is obliged to decide on the application within one month after having received it. The SSIA decision can be appealed following general administrative procedures.

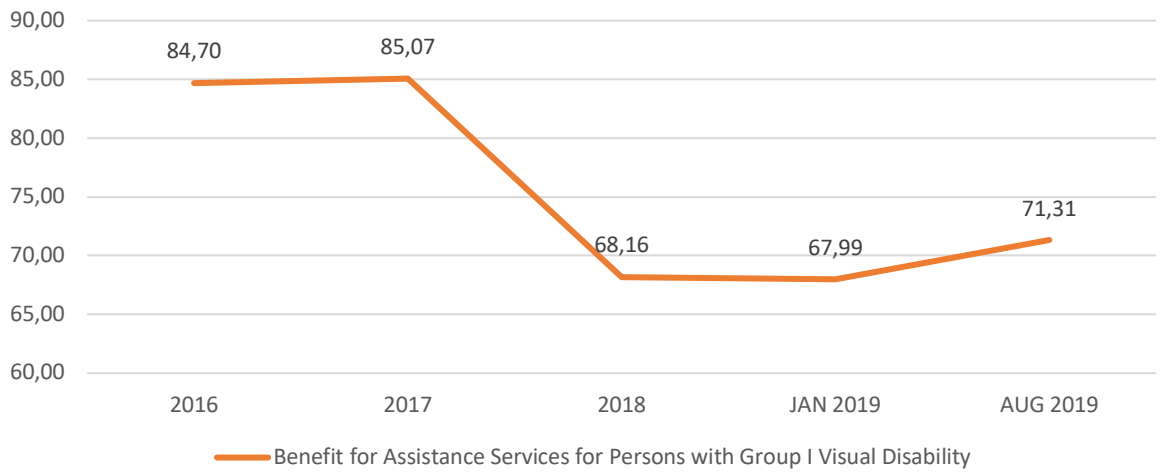
The level of the allowance is EUR 17.07 a week (initially meant for 10 hours a week; EUR 1.707 per hour). It is lower than the hourly minimum wage (about EUR 2.5 per hour – EUR 430 per month). Table 4.14 indicates the small number of beneficiaries that has stayed stable since 2016.

A number of benefit recipients is not more than 2.2 thousand persons per year. The average amount received by beneficiaries ranges from EUR 68.16 to EUR 85.07 per month. The recipient of the benefit does not have to account to SSIA for the services provided by the assistant.

Figure 4.15 and Table 4.14 present data the level of benefit and the number of beneficiaries, respectively.

[137] SSIA. "Budget and Statistics". November 2019. https://www.vsaa.gov.lv/par-vsaa/parmums/
[138] SSIA. Data on request.
[139] SSIA. Data on request.
[140] Cabinet regulation: *Regulation Regarding the Benefit for Assistance Services for Persons with Group I Visual Disability, 2014*. SI 2014/698. Riga: Cabinet of Ministers. https://likumi.lv/ta/id/270262-noteikumi-par-pabalstu-par-asistenta-izmantosanu-personam-ar-i-grupas-redzes-invaliditati

Figure 4.15 -Average level of the benefit for assistant services for persons with Group I Visual Disability



Source: SSIA

Table 4.14 -Assistant services for Group I Visual Disability - number of beneficiaries 2016-2019

August 2019	2,190
January 2019	2,195
2018	2,144
2017	2,100
2016	2,079

Source: SSIA

viii. Support for persons involved in the mitigation of consequences after the Chernobyl Nuclear Power Station (CNPS) accident

Allowance for persons involved in the mitigation of consequences after the CNPS accident: This allowance is regulated by *The Law on Social Protection of Participants Involved in the Mitigation of Consequences of the Chernobyl Nuclear Power Station Accident and Persons who have Suffered from the Accident*[141] and other pertinent regulation issued by the Cabinet of Ministers.[142] The purpose is to provide income support to these persons and their descendants.

To qualify for this allowance, a person should have a disability due to her/his participation in the mitigation of consequences of the Chernobyl NPS accident, as determined by SMC. Entitled to this allowance are also: one dependent child who is not older than 18 years of age (until 24 years of age if s/he studies full time at the secondary or higher education institution), a spouse, parents and grandchildren of a deceased participant in the mitigation of consequences of the Chernobyl NPS

[141] S.11 of this Law. The Law is available at: https://likumi.lv/doc.php?mode=DOC&id=17962

[142] Cabinet regulation: *Regulations on the State Social Allowance to Participants Involved in the Mitigation of Consequences of the Chernobyl Nuclear Power Station Accident and to Families of Deceased Participants in the Mitigation of Consequences After the Chernobyl Nuclear Power Station Accident, 2010*. SI 2014/698. Riga: Cabinet of Ministers. Available at: https://likumi.lv/doc.php?id=222142

accident, provided that cause of the death is related to the participation in mitigation. The allowance is administered by SSIA and funded by the state budget. Its level is EUR 100.0 and it is paid out monthly.

Administrative steps to receive this allowance include: (i) SMC determines disability and its causal link to the participation in the mitigation of consequences of the Chernobyl NPS accident. It transfers information to SSIA electronically; (ii) Potential beneficiary applies to SSIA to receive this allowance; (iii) The Medical Commission of the Centre for Occupational and Radiation Medicine of the P. Stradins Clinical University Hospital, Ltd. issues an opinion that the cause of the mitigation participant`s death is a disease that has a causal link to the participation and transfers it electronically to SSIA; (iv) A Court decision that establishes the descendancy. The Court send this information to SSIA; (v) The Ministry of Education and Science provides the SSIA with digital information about the applicant who studies in secondary education institution.

SSIA reviews the application and is mandated to decide within one month after having received it. The decision can be appealed following general administrative procedures for appeals. The allowance is awarded for the duration of disability and the person would continue to receive it as long as s/he is reassessed as having a disability. In case of other recipients: (i) a child of the deceased participant: until s/he reaches 18 years of age (24 years of age if s/he studies full time at the secondary or higher education institution); (ii) a grandchild until s/he reaches 18 years of age; (iii) a surviving spouse until the date s/he marries or becomes employed or self-employed. Table 4.15 presents data on beneficiaries of this allowance 2016-2019.

Table 4.15 -Allowance for persons involved in the mitigation of consequences of the CNPS accident - number of beneficiaries 2016-2019[143]

August 2019	3,185
January 2019	3,232
2018	3,297
2017	3,379
2016	3,430

Source: SSIA

Monetary compensation to a person involved in the mitigation of the Chernobyl NPS accident consequences with incapacity for work of 10 – 25 percent: This monetary compensation is regulated by *The Law on Social Protection of Participants Involved in the Mitigation of Consequences of the Chernobyl Nuclear Power Station Accident and Persons who have Suffered from the Accident*[144]. The purpose of this compensation is to provide income support: (i) to the Chernobyl accident mitigation participants who have been assessed as having a work capacity loss of 10-25 percent (in other cases a loss of work capacity of up to 25 percent is considered “no disability), and where a causal link between the two is established; and (ii) to the survivors of a deceased participant who have been granted a survivor’s pension and are not capable of working. The compensation is administered by SSIA.

The compensation is calculated following a formula: 50.0 percent of the average insurance contribution wage in the previous calendar year in the country times the loss of ability to work in percentage. For dependents: 50.0 percent of the average annual insurance contribution wage in the previous calendar year in the country times a coefficient according to the number of family members who have been granted a survivor's pension: 0.8 if there is one dependent, 0.9 if there are two dependents and 1.0 if there are three and more dependents. The ccompensation level is revised

[143] State Social Insurance Agency. “Budget and Statistics”. November 2019. https://www.vsaa.gov.lv/par-vsaa/parmums/
[144] S.11 of this Law. https://likumi.lv/doc.php?mode=DOC&id=17962

annually on the 1st of May, considering the average insurance contribution wage for the preceding calendar year. The recalculation is made by SSIA.

A benefit is granted for the established period of disability. It is continued based on the disability reassessment by SMC or change in the number of dependents.

To qualify for this benefit, an applicant should be assessed for work capacity by SMC that should also establish a causal link between the loss and the participation in the mitigation of the consequences of the Chernobyl NPS accident. This information is automatically transferred to SSIA. A person should submit an application to SSIA, which reviews it and should decide within a month after having received it. The decision can be appealed following general administrative procedures.

The compensation is paid out monthly in a manner chosen by the beneficiary (delivered at home address for a fee or deposited on her/ his bank or post system account.

Table 4.16 -Compensation to persons involved in the mitigation of consequences of the CNPS accident assessed as having lost work capacity by 10-25 percent and her or his descendants incapable of working - number of beneficiaries 2016-2019[145]

I-IX 2019	2,400
2018	2,386
2017	1,284
2016	1,250

Source: SSIA

A compensation beneficiary may at the same time receive a compensation and a state pension calculated and granted in accordance with the Law on State Pensions or compensation and the state social security benefit granted in accordance with the Law on State Social Allowances, or compensation and the service pension granted in accordance with the special service pension regulations.

The compensation is funded from the social insurance budget (maternity, sickness and disability budget) for disabled participants of the mitigation activities; and by the state budget for the family members. Table 4.16 presents data on the number of beneficiaries 2016-2019.

4.2.3 Social benefits to persons with disabilities provided by local governments

The Law on Social Services and Social Assistance[146] empowers municipalities to provide its residents social protection funded from their ow basic budget. While people with disabilities are entitled to benefit from those programs (e.g., guaranteed minimum income and housing allowance) under the same eligibility requirements and procedures as every other municipality resident, some municipalities have introduced programs specifically for them (see examples from four municipalities below).

Social benefits constitute one of the largest expenditure items in municipal budgets. The benefits they provide sometimes overlap with the state social benefits, calling for a harmonized and coordinated approach to the provision of publicly funded benefits to the population, including persons with disabilities. A common policy framework and a set of program-setting parameters with clear division

[145] State Social Insurance Agency. "Budget and Statistics". November 2019. https://www.vsaa.gov.lv/par-vsaa/parmums/

[146] Law on Social Services and Social Assistance 2002. Riga: Saeima. Available at: https://likumi.lv/ta/id/68488-socialo-pakalpojumu-un-socialas-palidzibas-likums

of responsibilities between the state and municipalities are needed to ensure adequate and efficient service provision and horizontal equity among recipients. The level of social protection should not depend on the place of residence.

Another issue is a general lack of community based social services provided to persons in need, including persons with disabilities. Latvia needs a concerted and persistent effort of all stakeholders to advance local service development, which, in turn, would enable it to end a practice of service provision in residential institutions.

Below, we provide examples of social programs for people with disabilities established in four municipalities.

(i) Riga City: Payment of transport services to persons with difficulty in moving around and unable to use public transport.

Regulated by the Riga City Municipality,[147] and based on *The Law on Social Services and Social Assistance.*[148]

Persons who have declared a residence in the administrative territory of the Riga City, do not receive long-term social care services or social rehabilitation services in a residential institution, are not in prison and have difficulty "moving around" and are not able to use public transport are entitled to this allowance. To qualify, they should also have a SMC opinion on medical indications for the acquisition of a specially adjusted car and for the receipt of an allowance for the compensation of transport expenses; or a person with disability, then a SMC opinion about needing to use specialized transport (mini bus), a taxi or to purchase a fuel, or if the person has chronic kidney failure requiring hemodialysis. If the person is not issued the SMC opinion, then if s/he cannot use public transport for justified reasons such as, needing to travel to and from an institution to get health care, rehabilitation, or social cares services.

To obtain this transport allowance, a person should submit an application to the Riga Social Service. She or he must present a personal identification document and also submit the following documents:

For patients with chronic kidney failure, an extract from a hospital/outpatient medical card issued by a primary health care physician or a treating physician stating the need and period for receiving the services;

For a person who, for justified reasons, is not able to use public transport: an extract from a hospital/outpatient medical card issued by a primary health care doctor or a treating physician justifying the person`s inability to use public transport; also, a referral to a rehabilitation institution or a document confirming the services and their duration;

For persons with disabilities who are studying, for the first school year semester, a document confirming admission to the educational establishment, then, every six months thereafter, a statement from the school that the person has completed the previous semester and continues studies, or a copy of the contract for the commencement of skills development or upgrading courses;

[147] Riga City Council. "On Procedure Regarding the Payment of Transport Services to Persons with Functioning Impairments Unable to Use Public Transport", 2018. Binding Regulations of the Riga City Council 2018/23. https://likumi.lv/ta/id/297208-par-transporta-pakalpojumu-samaksas-kartibu-personam-ar-funkcionaliem-traucejumiem-kuras-nevar-parvietoties-ar-sabiedrisko-transportu

[148] See: https://likumi.lv/ta/en/en/id/68488

For persons with disabilities who work, every six months a statement from the employer indicating the duration of the employment contract.

Documents can be submitted in person, by post or by electronic means with a secure electronic signature. The Social Service Office should decide within 10 days. The decision can be appealed first to the Welfare Department of the Riga City Council within one month, whose decision can then be appealed to the Administrative Court, also within one month, after having been received.

The allowance is EUR 284.57 per year or EUR 23.72 per month. In addition, EUR 21.34 may be received if a person studies or attends long-term (for not less than one month) courses to obtain/improve skills, is employed or a member of the board of a non-governmental organization; EUR 71.14 per year, if attending an institutions to get social, vocational or medical rehabilitation services. For patients with chronic kidney failure the allowance is EUR 71.14 per month.

Table 4.17 -Riga City transport allowance to persons with disabilities: beneficiaries and spending 2016-2018

Year	Beneficiaries	Spending in 000 EUR
2018	7,940	1,843
2017	7,389	1,733
2016	6,955	1,617

Source: Annual Report "Social system and health care in 2018", 2019. Riga: Riga City Council Welfare Department. Available at: http://www.ld.riga.lv/lv/par-departamentu/par-mums/labklajibas-departamenta-gadagramatas.html /

The allowance is paid to a person with disabilities account quarterly. For patients with chronic kidney failure, it is paid out monthly.

This benefit is funded by the Riga City budget and administered by the Riga Social Services Office.

Table 4.17 presents data on the number of beneficiaries and spending on this benefit. Both the number of beneficiaries and the spending increased relatively fast - by 14.0 percent between 2016 and 2018.

(ii) Ventspils City: Allowance for pensioners and persons with disabilities to purchase medicines and medical devices

Regulated by the Ventspils City Municipality[149] based on *The Law on Social Services and Social Assistance[150] and The Law on Local Governments.*[151]

This allowance is targeted at non-working pensioners and non-working persons with disabilities who have declared their place of residence in the administrative territory of Ventspils City and are reachable at the declared address, to partially cover the purchase of medicines and medical devices (e.g. stoma care goods), on condition that their pension does not exceed EUR 338.0 per month (before taxes). This is the only income tested benefit reviewed thus far in this chapter.

[149] On the Determination of the Status of Low-Income Family (Person) and the Procedures for the Receipt of Local Government Social Benefits in Ventspils City, 2018. Binding Regulations of Ventspils City Council 2018/8. Available at: https://likumi.lv/doc.php?id=245445

[150] See: https://likumi.lv/ta/en/en/id/68488

[151] The Law on Local Governments 1994. Riga: Saeima. https://likumi.lv/ta/id/57255-par-pasvaldibam

The allowance is granted on the basis of documents certifying relevant expenditures during the current year (including the name of the applicant, personal identity number, and medicinal products purchased) A person must submit an application to the Social Service Office and provide required documents. The Social Service Office must decide within 10 days. The decision can be contested with the Head of the Social Service Office within the time limit specified in the decision. Her/his decision can be appealed to the Administrative District Court in accordance with the procedures specified in the Law.

The allowance is funded from the municipal budget and it is administered by the Ventspils City Social Service Office. It is currently EUR 36.00 per year, and it is paid once a year. It can be transferred to the beneficiary account or received at the Social Service Office cash-desk.

Data on the number of beneficiaries is not available. The total amount of allowances for low-income pensioners and people with disabilities, as well as for pensioners and persons with disabilities whose income level does not exceed the level determined by Ventspils City Council was EUR 970,000 in 2018 or 53.0 percent of the total funds spent on social assistance and social services.

(iii) Valka Municipality: Apartment (housing) and fuel allowance

Regulated by the Valka Municipality Council[152] based on *The Law on Social Services and Social Assistance[153] and The Law on Assistance in Solving Apartment Issues.*[154]

This allowance targets single persons with disabilities who have declared Valka municipality as their residence. The purpose is to partially cover rental cost and public cost of an apartment , not exceeding the actual cost or to partially cover fuel cost. It is also income tested.

An apartment allowance may be received by a single person with disabilities, if: she/he is unemployed, living separately from legal survivors or without any legal survivors; whose income does not exceed 75.0 percent of the national minimum wage; and whose movable and immovable property is assessed in accordance with the Cabinet of Ministers regulations and the binding regulations of the local government regarding the procedures by which the person is recognized as in need. The allowance is granted for an apartment or house in which the person resides. The fuel allowance can be received by a single person with a disability who lives in a dwelling heated with wood and which is owned by her/him, or who is renting a house. During a calendar year a person may receive one of these two allowances.

The allowance is implemented by the Valka Municipality Social Service Office and it is funded from the municipality budget. The rental allowance is EUR 25.0 per month, while the fuel allowance is EUR 60.0 per year.

To get the allowance, a person ought to submit an application to the Social Service Office and present a personal identification document. The Social Service Office should decide within 10 working days. The decision may be appealed to the Head of the Social Service Office, whose decision may be appealed to the Administrative District Court in accordance with the procedures specified in the Law.

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[152] "Apartment (housing) allowance in the Valka municipality, 2012. Binding Regulations of Valka municipality 2012/23. Available at: http://www.valka.lv/wp-content/uploads/2011/11/saist_not_nr23_2012.pdf

[153] See: https://likumi.lv/ta/en/en/id/68488

[154] The Law on Assistance in Solving Apartment Issues 2001. (s.25 (10), Riga: Saiema. Available at: https://likumi.lv/ta/id/56812-par-palidzibu-dzivokla-jautajumu-risinasana

The housing allowance is granted for a period of six months. The fuel allowance is granted and paid once a year. To receive this allowance in the subsequent period, a new application must be submitted.

No separate date for persons with disabilities receiving housing allowance is available. In total, 687 persons received housing allowance in 2018 (737 persons in 2017).[155] The total spending on apartment (housing) allowance was EUR 85,658 in 2018 (EUR 82,086 in 2017).[156]

(iv) Dagda Municipality: Allowance for services provided to disability pensioners

Regulated by the Dagda Municipality Council[157] based on *The Law on Social Services and Social Assistance*[158] *and The Law on Local Governments.*[159]

This allowance targets needy (income level of EUR 128.06 per month per person) and low-income (income level EUR 200.0 per month per person) persons with disabilities, living alone and residing on the territory of Dagda Municipality. The purpose is to help them partially meet the cost of boarding and lodging in medical, social rehabilitation, crisis centers and other institutions, and the costs of physical and mental health care in accordance with the agreed co-participation measures and/or social rehabilitation plans.

The allowance is implemented by the Dagda Municipality Social Service Office and it is funded from the municipality budget.

To get the allowance, a person must apply to the Social Service Office and present required documents. The Office evaluates the application and the social situation of the applicant. The decision is made based on an opinion of the social worker on the positive cooperation with a person for the achievement of social rehabilitation objectives and/or a justified need to meet the basic needs of a person. The decision may be appealed to the Dagda municipality Council, which can then be appealed in accordance with the procedures specified by the Administrative Procedure Law.

The allowance amounts to EUR 150 per year. A new application is needed for a person to receive it the next year.

Data on the number of recipients and spending is not disaggregated by disability. The total expenditure on social benefits for 2018 was EUR 453,691 or 5.1 percent of the total basic budget of the municipality. Compared to 2017 (EUR 484,820), the expenditures declined by 6.4%.[160]

4.2.4 Social Services

Social services are regulated by *The Law on Social Services and Social Assistance,*[161] which specifies types of social services provided, principles of their provision and receipt, target populations, funding and administrative arrangements. The Law specifies three groups of services: social care, social

[155] Annual Public Report 2018 of Valka municipality, 2019. Valka: Valka municipality Council. Available at: http://www.valka.lv/wp-content/vnd_gada_parskats.pdf
[156] Ibid.
[157] "On Social Assistance in Dagda municipality", 2017. Binding Regulations of Dagda municipality 2017/8. http://www.dagda.lv/fileadmin/Pasvaldiba/Saistosie_noteikumi/2017/SN_Nr.8_par_soc.palidzibu.pdf
[158] See: https://likumi.lv/ta/en/en/id/68488
[159] Ibid.
[160] Annual Public Report of Dagda municipality 2018, 2019. Dagda: Dagda municipality Council. Available at: http://www.dagda.lv/uploads/media/DAGDAS_NOVADA_PGP_2018.pdf
[161] The Law on Social Services and Social Assistance 2002. https://likumi.lv/ta/id/68488-socialo-pakalpojumu-un-socialas-palidzibas-likums

rehabilitation and vocational rehabilitation.[162] Persons with disabilities are one of the groups identified as eligible to receive services, provided that they meet other eligibility requirements set by this Law. Separate services intended for persons with disabilities are also specified by *The Disability Law.*[163]

Below, we briefly discuss the three groups of services.

i. Social care services

Social care services are a set of measures aimed to meet basic needs of persons who, due to old age or functioning difficulties experience problems in taking care for themselves. Social care services can be received at home, including home care services, day-care centers, service apartments or group homes (also known as community-based services) or at the long-term state social care institutions (SCI).

The state budget funds services of SCI for: (i) adults with mental health disorders placed in these institutions before January 1, 2003; (ii) blind adults; (iii) persons with severe and very severe mental health and functioning disorders in need of institutional care; (iv) children with severe and very severe mental and physical disorders under the age of four and children with severe and very severe mental health disorders aged 4-18 years for whom family, guardian or foster family could not have been secured. Adults who receive a state pension or compensation should pay 85.0 percent of the cost of services.

The state budget also partially covers the cost of day care centers for persons with mental disorders, group house or apartment and half-way homes. The cost of placement in group houses or apartments established on the basis of SCI within the scope of the national program of the European Regional Development Fund (ERDF) are covered by the state 100 percent.[164]

The cost of other care services must be borne the person or her/his provider, if the person's resources are not sufficient. Persons with a needy person`s status are exempt. The Law and relevant Cabinet regulation determine an amount of financial resources that must remain in the possession of the person and the provider. If the provider has insufficient means, then the uncovered part of the service is funded by the local government. According to the Law, local governments may determine groups of beneficiaries who are exempt from payment for social services.

In principle, local governments are responsible for providing social services to citizens. They may provide services themselves by establishing service providers, or by purchasing services from other local governments, NGOs or private service providers. Below we provide some statistics on social care services, beneficiaries, residential institutions and public spending.

Overall, in 2018, there were in Latvia 14 long-term SCIs for adults funded by the state, 104 long-term SCIs for adults funded by local governments and 29 SCIs for children (Figure 4.16). Since 2016, the number of state funded SCIs for adults was decreased by one institution, and by four SCI for children. The number of long-term SCIs financed by local governments and other organizations increased by 16 between 2016 and 2018.

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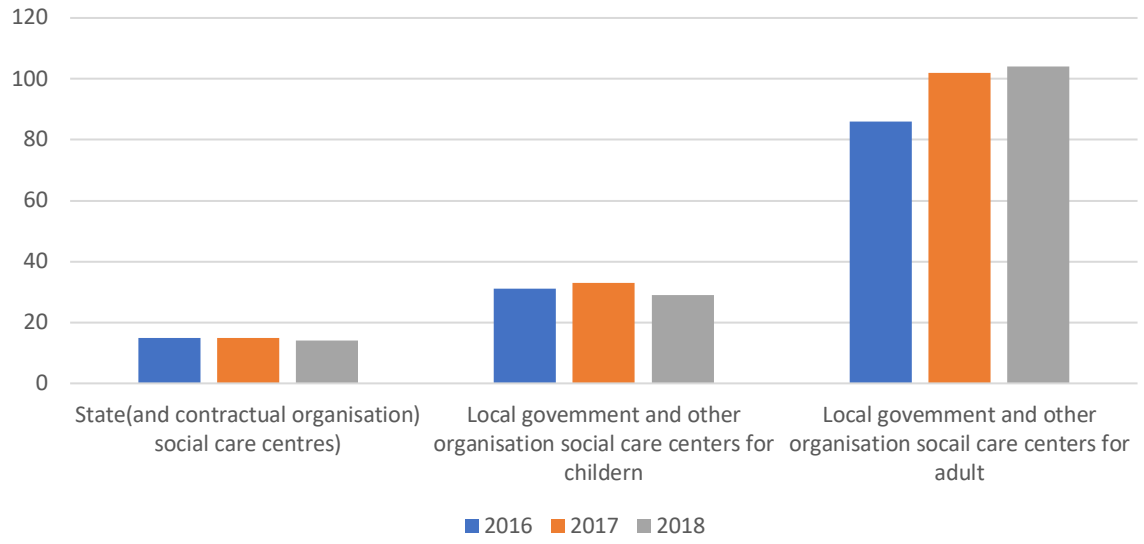
[162] These services can be disaggregated further: by age (children and adults), by funding (state and local governments), by the target group (persons of retirement age, persons with mental disorders, persons with functioning disorders, etc.).
[163] Ibid. https://likumi.lv/ta/id/211494-invaliditates-likums
[164] The details on funding can be found in the Law on Social Services and Social Assistance 2002. (s.13). https://likumi.lv/ta/id/68488-socialo-pakalpojumu-un-socialas-palidzibas-likums.

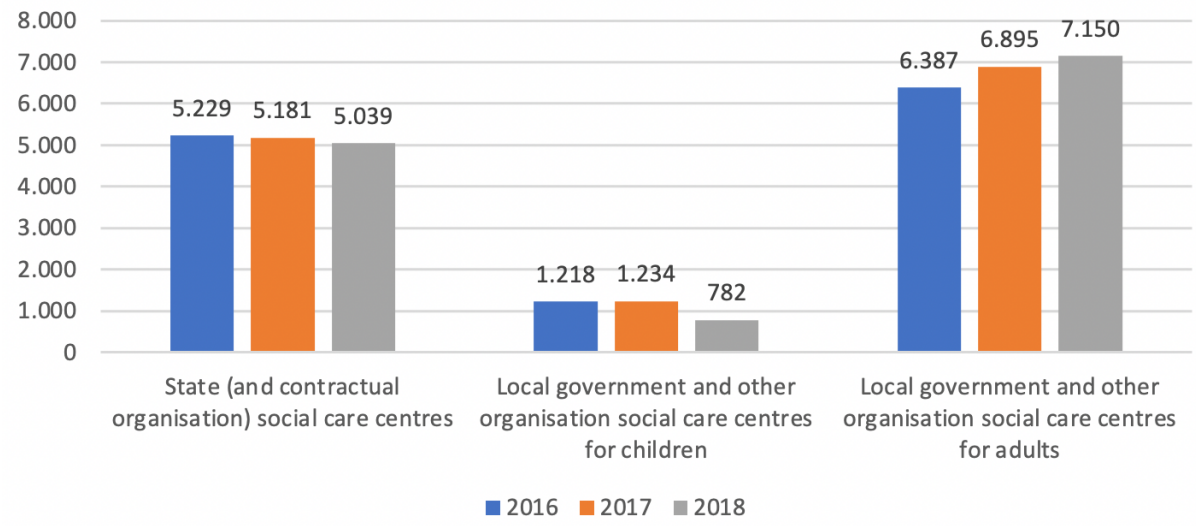
Between 2016 and 2018 the number of persons in state-funded SCIs for adults decreased by 190 persons or by 3.6 percent; the number of children declined by 35.8 percent, while the number of persons placed in local government long-term SCIs for adults increased by 11.9 percent (Figure 4.17). (There is a possibility that some of the residents from closed state-funded SCIs were placed in local government-run SCIs.)

Figure 4.16 -Number of long-term social care institutions 2016-2018



Source: Central Statistical Bureau of Latvia. Database: Long-term social care and rehabilitation centers at the end of the year. Available at: https://www.csb.gov.lv/en/statistics/statistics-by-theme/social-conditions/social-security/tables/sdg110/long-term-social-care-and-rehabilitation.

Figure 4.17 -Number of residents in publicly funded long-term social care and social rehabilitation institutions



Source: Ministry of Welfare. Publications, research and statistics. National statistics in the field of social services and social assistance. Annual data. Available at: http://www.lm.gov.lv/lv/publikacijas-petijumi-un-statistika/statistika/valsts-statistika-socialo-pakalpojumu-un-socialas-palidzibas-joma/gada-dati.

Within the same period, the state budget expenditure for adult care in long-term SCIs increased by 18.0 percent (Figure 4.18). In per capita terms, the cost per month per resident increased by 22.0

percent (significantly above the inflation rate) -- from EUR 636 in 2016 to EUR 778 in 2018. Co-financing for the development of local government alternative (community-based) care services, which was almost negligible to start with, decreased by 31.0 percent over the same period (Figure 4.19).

Figure 4.18 - State budget spending on long-term social care (EUR 000)

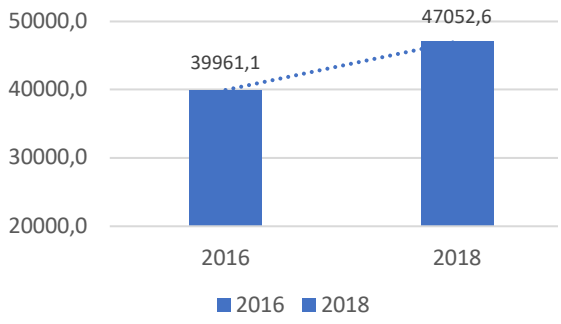
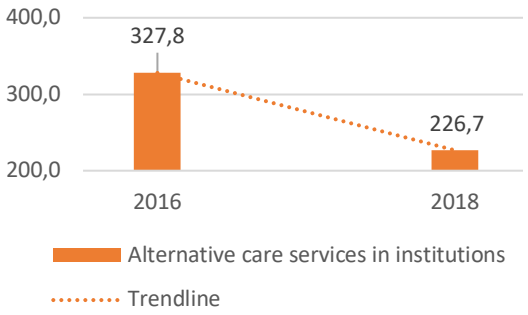


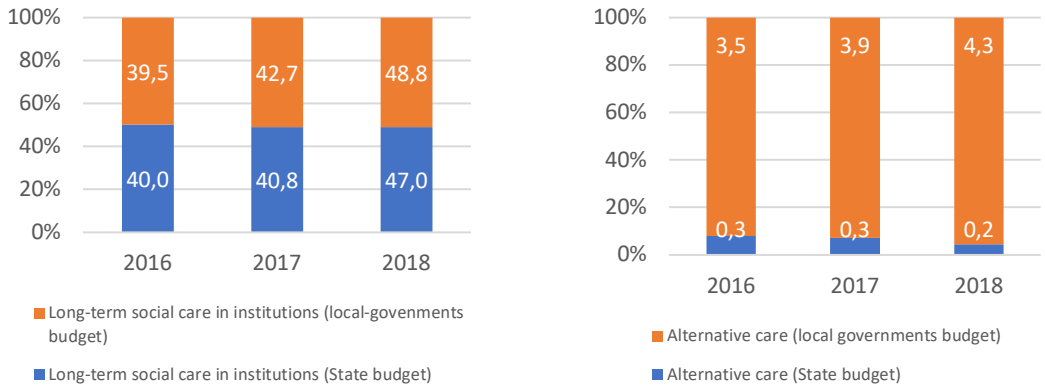
Figure 4.19 - State budget spending on alternative care services (EUR 000)



Source: MOW

Finally, spending by local governments on long-term institutional care increased by 24.0 percent between 2016 and 2018. Spending on alternative (to institutional care) forms of services increased as well: by 23.0 percent (Figure 4.20). However, spending on alternative services represented only 4.4 percent of the overall spending on social services in 2018. In total, Latvia spent about 0.3 percent of GDP on social services in 2018.

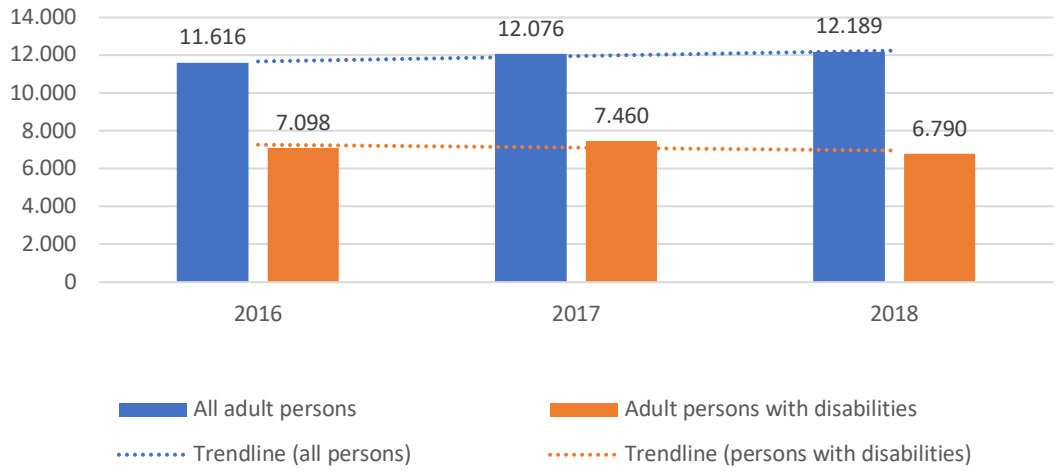
Figure 4.20 -State and local governments spending on social care (million EUR) 2016-2018



Source: Ministry of Welfare

Persons with disabilities constitute a significant fraction of people placed in long-term residential care institutions, although the share has declined since 2016: in 2016, 62.0 percent of all adults in long term SCIs were persons with disabilities (56.0 percent in 2018) (Figure 4.21).

Figure 4.21 -Adults in long-term institutional care (total and persons with disabilities)



Source: Central Statistical Bureau and MOW

Of all adults with disabilities, 4.07 and 3.7 percent were placed in long-term SCIs in 2016 and 2018, respectively. In the case of children with disabilities the proportion was 3.8 and 3.1 percent, respectively (Table 4.18).

Table 4.18 - Persons with disabilities and social care services

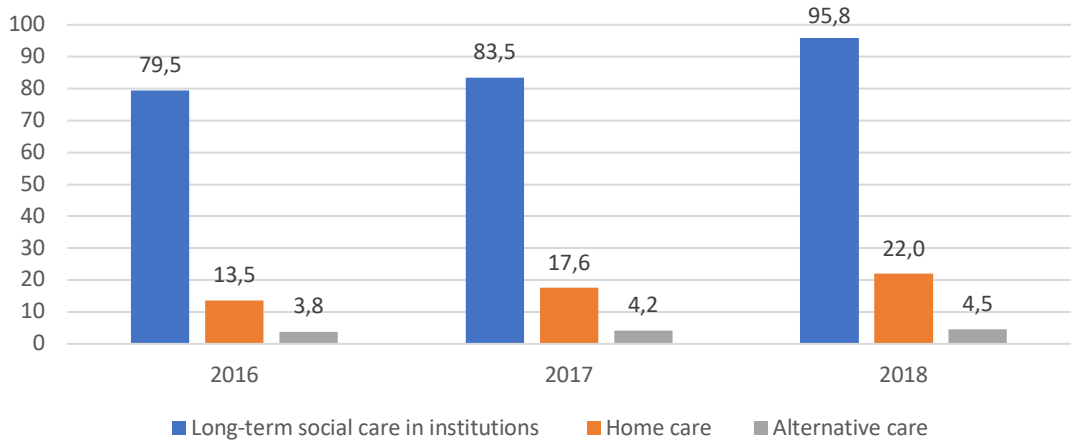
	2016	2017	2018
Number of persons with disabilities	182,792	187,830	191,815
Of which, children with disabilities	8,362	8,292	8,205
Share in total population (%)	8.14	9.25	9.99
Number of adults with disabilities in institutions	7,098	7,460	6,790
% of all adults with disabilities	4.07	4.16	3.70
Number of children with disabilities in institutions	315	312	256
% of all children with disabilities	3.77	3.76	3.12
Number of persons with disabilities receiving care at home	2,216	2,231	2,352
% of all persons with disabilities	1.21	1.19	1.23
Number of persons with disabilities in day care centers	1,702	1,631	1,611
% of all persons with disabilities	0.93	0.87	0.84
Number of disabled people with mental disabilities	23,202	23,786	24,175
% of all persons with disabilities	12.7	12.7	12.6
Number of disabled persons in homes (apartments)	236	241	253

Source: MOW

Only about 6.0 percent of all people with disabilities receive one type of care services. Care services in long-term SCIs prevail by far, followed by services provided at home and day care services. Very few are placed in group houses or apartments for people with mental disabilities.

Between 2016 and 2018 public spending on social care services increased significantly: spending on long-term care in SCIs (combining state and municipal SCIs) by 21.0 percent, on care services provided at home by 63.0, and on alternative care services by 19.0 percent (Figure 4.22). Spending on long-term residential care is dominant: 78.3 percent in 2018 (83.0 percent in 2016).

Figure 4.22 -Public spending on social care services (EUR million)



Source: Ministry of Welfare. Publications, research and statistics. National statistics in the field of social services and social assistance. Annual data.
http://www.lm.gov.lv/lv/publikacijas-petijumi-un-statistika/statistika/valsts-statistika-socialo-pakalpojumu-un-socialas-palidzibas-joma/gada-dati.

The data provided above suggest a poorly developed system of social care services dominated by institutional care, overall and for persons with disabilities. This is a puzzling finding, given that Latvia has been going through a process of deinstitutionalization of care -- including the development of community-based services -- since the late 1990s. The data thus suggest a very slow, even stalled process of deinstitutionalization and transition from institutional to community-based care.

As part of the EU programming period 2014-2020, several deinstitutionalization projects were launched with a view to promoting community-based services for people with mental disorders and disabled children. One of the results to be achieved is to provide alternative care services in municipalities for 700 persons who had previously received care services in the state funded SCI. Another expected result is the provision of community-based services (social rehabilitation, day care centers, respite services and social care services) for 2,100 disabled children with the active involvement of local governments in building the necessary infrastructure of community-based services. The projects are expected to be completed by the end of 2020.

It is noteworthy, however, that public attitudes are changing very slowly and "returning" SCI's resident to their communities is difficult without increased state financial support. Local authorities have not established necessary infrastructure to provide community-based services for both children and adults with disabilities. These care services should be developed with a view to providing home and family care, reducing institutional placement and reducing the impact of fees on receipt of needed services. The fact that the local government reform was launched only in 2019 has also played a part in the slow development of social care services.

In any case, the factors driving the pace of deinstitutionalization of care are complex, and MOW should conduct an in-depth assessment of the process (including admission criteria and funding), in order to identify obstacles and facilitators for its faster implementation.

Actions that MOW could take in the short- to medium-run to foster faster transition from institutional to community based social care services include:

- Incentivizing the implementation of the national policy for the development of community based social care services, i.e. services alternative to institutionalization.

- Instituting a principle of non-institutionalization at national and local level, instead of de-institutionalization. A strategic plan is required that would combine community-based services development, mandate no new placement into residential care, planned increased discharge from institutional care to community-based options, and a timeline. Deinstitutionalization is a long-term process that needs to be carefully planned and executed, keeping in mind the interest of the employees and the residents.
- Increasing the state financial support for local authorities to provide alternative care services.
- Making changes to the *Law on Social Security and the Law on Social Services and Social Assistance* in order to establish a minimum package of social care services that can be received free of charge; (ii) oblige local governments to fully pay for long-term social care services in institutions.

ii. Services of an assistant

The Disability Law[165] *includes* the right of people with disabilities to services of an assistant. The Law defines an assistant as a person "who provides assistance to a person with a very severe or severe level of functioning limitations in performing activities outside his or her dwelling, which due to his or her disability cannot be performed independently: to get to a place where she or he is studying, working, receiving services; to move about and to take care of herself or himself in an educational institution, in a place of paid employment; to be in contact with other persons and legal entities, as well as assist a person with visual disability to acquire a program of basic vocational education, secondary vocational education or higher education". The following persons with disabilities have the right to assistant services:

- Persons with Group I Visual Disability;
- Persons with Group I and Group II disabilities and a person with disabilities from childhood (for whom SMC as issued an opinion on medical indications for the special adaptation of the passenger car and the receipt of a benefit for the reimbursement of transport costs; anatomical defects of both upper extremities: amputation stumps at or above of the base of the hand; or mental health disorders);
- Persons with disabilities attending primary, general and vocational primary education, vocational education, general and vocational secondary education institutions and persons with Group I and Group II disability studying at universities and colleges.[166]

The services of an assistant are provided by the social service office of the local government at the person's place of residence.[167] Upon receipt of an application, the social service office of the local government should decide within one month. The decision, if service is granted, should specify the scope and duration of the service. The relationship between the assistant, the recipient of the service and the social service office is regulated by a mutually concluded contract specifying the scope of the assistant's service, the duration and procedures for the provision thereof, rights, duties and responsibilities, settlement procedures and other relevant issues related to the provision of the assistant's service, as well as the conditions for termination of the contract. Once a month an assistant

[165] Ibid. (s.1, 12). https://likumi.lv/doc.php?id=211494

[166] Procedures for Granting and Financing Services of an Assistant in Local Government, High School and College, 2012. SI 2012/942. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/253781-kartiba-kada-pieskir-un-finanse-asistenta-pakalpojumu-pasvaldiba.

[167] To acquire services of an assistant, a person should submit written application to the social service office (personally, by post or electronically). Documents to be submitted as well: personal identification, SMC opinion on the need for assistant services; a statement from an employer, educational establishment, day care center, rehabilitation institution or any other institution, which the person needs to visit.

must submit a service recording sheet to the social service office. The social service office is obliged to monitor and audit the service statements.

The decision of the social service office may be contested to the relevant local government council, whose decision may then be appealed to the administrative court.

Assistant service it suspended when a person is in the long-term social care institution, hospital or prison. It is terminated if a person refuses the service, has declared that his or her place of residence is in another local government, when the term of validity of the SMC opinion has expired or the social service office determines that the assistant's service has not been used.

The assistant remuneration is based on the national minimum wage hourly rate within normal working hours and includes mandatory state social insurance contributions of the employer. The cost of transport is paid as well. Local governments are granted 10.0 percent of the budget appropriated to this service.[168] They can also increase the assistant remuneration in accordance with the financial resources available in their budgets.

The total duration of an assistant service cannot exceed 40 hours per week. The number of hours varies, as presented in Table 4.19:

Table 4.19 -Number of hours of assistant service

Case	Number of hours
A person works or carries out an economic activity	Time needed to get to and from work. Not more than 20 hours a week.
A person is a pupil	Time needed to get to and from school. Not more than 20 hours a week.
A person studies at the university orcolledge	Time needed to get to and from university and attend classes. Not more than 40 hours a week. Only during the school year.
A person gets services at the community based social care or rehabilitation centre	Time needed to get to and from the center. Not more than 20 hours a week. Individual approach, taking into account the needs of a person and the demand for the service.
A person undergoes treatment, visits the state and local government institutions, financial institutions, bodies for the protection of the interests of persons.	Time needed to get to and from an institution and the time spent in the institution. Not more than 20 hours a week. Individual approach taking into account the needs of a person and the demand for the service.
Participation in social events and activities	Time to get to and from the place of activity. Not more than 20 hours a week. An individual approach taking into account the needs of a person and the demand for the service. In case of children with disabilities – time spent at the event or activity.
Persuit of leasure activities in free time	Not more than two hours per week.

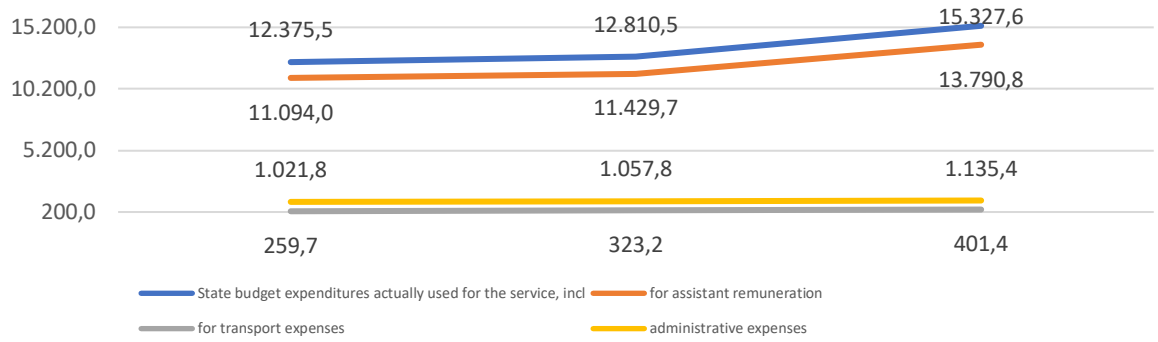
[168] The administration cost includes staff salaries, facilities (rent, utilities), stationery goods, machinery and equipment, transport expenses related to the fulfilment of contractual obligations, as well as other expenses related to the provision of an assistant service in the local government.

According to data from the Union of Local Governments in 2018,[169] the age composition of the recipients of the assistant service was: (i) children with disabilities aged 5-7 years: 2.0 percent; (ii) children with disabilities aged 8-17 years: 8.0 percent; (iii) persons with disabilities aged 18-26 years: 7.0 percent; (iv) persons with disabilities aged 27-60 years: 36.0 percent; and (v) 61 + years of age: 47.0 percent. More than a half (55.4 percent) of all users of the service used an assistant to pursue leisure activities and visit a doctor or an institution. Of all service providers, 72.0 percent were relatives of persons with disabilities, and only 28.0 percent were other persons. None of the stakeholders appears to be satisfied with this service. Service recipients complain of complex application and demanding reporting arrangements, excessive bureaucracy, low assistant pay. Local governments point to the lack of the common approach to assess needs, complex administration, and reporting requirements that infringe on the person's privacy. MOW notes that the client's needs are not adequately assessed.[170]

The State Audit Office in the audit report "Does the assistant service provided to persons with disabilities achieve the objectives of its establishment?"[171] published on 18 March 2016 notes the need to improve the procedures for determining and administering the needs for services of an assistant. Following on the report by the State Audit Office, MOW started to work on the improvements to the assistant services, but no significant changes have been made yet. Anecdotal evidence suggests that most reservations about proposals that have been tabled have come from the parents of disabled children who are making a case for a full time (40 hours per week) assistant services at an increased hourly rate for children starting at 1.5 years of age. The discussion is often dominated by the issue of remuneration, rather than the need for service and its content.

Public spending on assistant services has increased fast in just two years (2016-2018) - total spending by almost 24.0 percent; assistant's remuneration also by 24.0 percent, transport cost by 54.0 percent and administrative expenses 11.1 percent (Figure 4.23). On average, the beneficiary of this service received EUR 98.0 per month (administrative expenses excluded) in 2016 and EUR 114.0 per month in 2018 – 16.3 percent – about double the consumer price index (by way of comparison, the basic social security benefit in 2018 was EUR 64.0 per month, the same as in 2016).

Figure 4.23- Public spending on assistant services 2016-2018 (budget execution in 000 EUR)

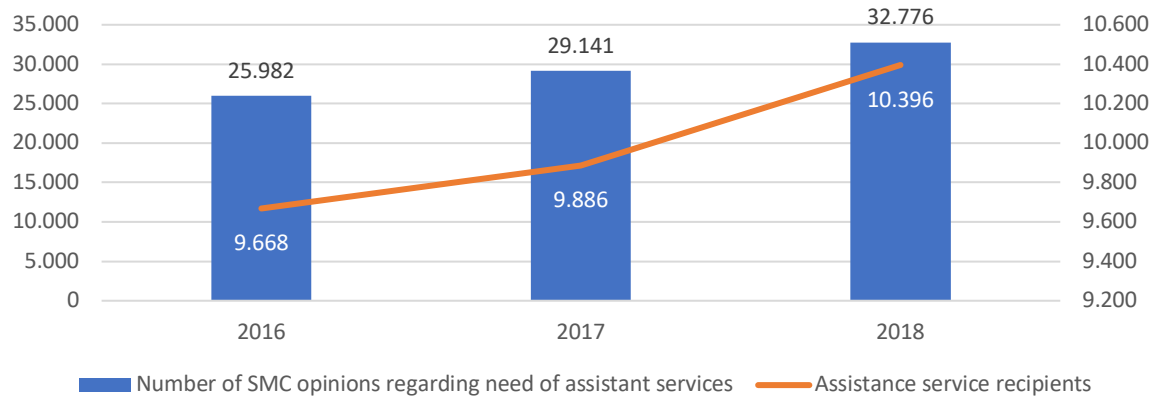


Source: MOW

[169] Assistant service in municipality. Fact sheet. 2019. Riga: Latvian Association of Local and Regional Governments. Available at: https://www.lps.lv/uploads/docs_module/Faktu_lapa_asist_pak_izmainas.pdf
[170] Ibid.
[171] Audit report: "Does the assistant service provided for persons with disabilities achieves the objectives of its establishment?" 2016. Riga: State Audit Office. Available at: http://www.lrvk.gov.lv/revizija/vai-personam-ar-invaliditati-paredzetais-asistenta-pakalpojums-nodrosina-ta-izveidosanas-merku-sasniegsanu/

The demand for these services and the complexity of eligibility testing and award decisions is reflected in the fact that there is a significant difference between the number of persons with disabilities who have received an SMC opinion about the need for this service and the number of recipients. Between 2016 and 2018 a number of opinions issued by SMC on the need for an assistant service increased by 26.1 percent. The number of beneficiaries increased by 7.5 percent over the same period (Figure 4.24).

Figure 4.24 -The number of SMC opinions on the need for assistant services and the number of the service recipients 2016-2018



Source: MOW and SMC.

In just two years, the share of persons with disabilities for whom SMC issued an opinion on the need for assistant services increased by 20.0 percent: from 14.2 percent of all persons with disabilities to 17.0 percent. This is a trend that needs a thorough analysis to understand its determinants -- whether severity of disability, increased activity and participation of persons with disabilities, soft criteria for decision making, etc. are among factors driving this increase. Who provides the services and for which activities should be examined: currently, most of service providers are relatives and most of the services are used for leisure, to visit a doctor or an institution or a public office. Ideally, the services should be professionalized and provided by third parties. With good planning and the use of modern technology to schedule services (e.g. an app), significant efficiency gains can be achieved.

To conclude, MOW should conduct an in-depth analysis with a view of tightening eligibility criteria and rules concerning service providers and monitoring and reporting arrangements.

iii. Social rehabilitation

The *Law on Social Services and Social Assistance* defines the term "social rehabilitation service" as "a set of measures aimed at the renewal or improvement of social functioning abilities in order to ensure the recovery of social status and integration into society and includes services at the place of residence of the person and/or at a social care and social rehabilitation institution".[172] According to this definition, statutory *social rehabilitation services* are: (i) specialized workshops that promote skills development and provide support of specialists to persons with functioning limitations; (ii) technical aids – provision of equipment/ technical devices and systems that rectify, compensate, relieve or neutralize the reduction of a function or disability; (iii) half-way houses where the acquisition or strengthening of self-care skills and life competences necessary for an independent life is ensured for persons with functioning disorders; (iv) psychosocial rehabilitation through which a person or his or

[172] Ibid. (s.1). https://likumi.lv/ta/id/68488-socialo-pakalpojumu-un-socialas-palidzibas-likums

her family receives support for resolving psychosocial problems; and services provided by (v) social rehabilitation centers to restore social functioning capacity for persons with functioning limitations.

The following services are financed from the state budget specifically for persons with disabilities: social rehabilitation of persons with impaired vision and hearing; technical aids; social rehabilitation services for restoring capacity to work in social rehabilitation institutions for working age persons with functioning disorders (including those who are employed); psychosocial rehabilitation for persons with oncological diseases and their family members, as well as for children in palliative care and their family members.[173]

The provision of social rehabilitation services to persons with impaired vision and hearing is delegated to non-governmental organizations (NGOs): The Latvian Society of the Blind (LSB) and The Latvian Association of the Deaf (LAD); the provision of psychosocial rehabilitation services to persons with oncological diseases, to the Latvian Cancer Patient Support Society "Dzīvības koks"; for children in a palliative care, to the Children's Palliative Care Society. Technical aids are provided by the state limited liability company "NRC "Vaivari" with some exceptions (the tiflotechnology and surdotechnology is provided by the Latvian Society of the Blind and the Latvian Association of the Deaf, respectively). Social rehabilitation services for the restoration of capacity to work are provided by the Social Integration State Agency (SISA), under MOW.

Social rehabilitation services provided by SISA

These services are provided by residential facilities. Those who are entitled to receive social rehabilitation services from SISA are: politically repressed persons, participants involved in the mitigation of consequences of the Chernobyl NPS accident, persons with functioning limitations and persons of working age with predictable disability, as well as elderly persons with functioning limitations who are employed, if their status of functioning meets the criteria[174] specified in the Cabinet Regulations.[175]

Duration of the service is up to 21 days and it is provided in residential setting with well-appointed and well-equipped facilities. The person can receive a repeat service of 14 days, but only two years after the completion of the previous service and if the person's functioning capacity was reduced. Chernobyl NPS accident mitigation participant may receive the service once per year, and persons with predictable disability have a priority to receive the service once during the predictable disability period determined by SMC. There is a waiting list for the service. There are also specific provisions for cases where the services are requested as a matter of urgency, within six months of the completion of the medical rehabilitation treatment.

Administrative process to access the service involves a family doctor, social service office and SISA. A family doctor prepares an opinion on the necessity for the service and attaches medical documents (a copy of the medical rehabilitation statement or the individual rehabilitation plan approved by SMC) to support the opinion. A person submits these documents and an application to the social service office of the local government, but a person with a predictable disability – to SISA in person, by post or in the form of an electronic document. Within 10 working days a social service office conducts a

[173] Ibid. (s.13). https://likumi.lv/ta/id/68488-socialo-pakalpojumu-un-socialas-palidzibas-likums

[174] In accordance with the ICD (medical diagnoses codes referred to in chapters G, M, T and Q) and Section "Activities and Participation", domains d4, d5, d6 of the ICF). For ICF, see Chapter Tree of this study.
Also: https://www.who.int/classifications/icf/en/

[175] Regulations Regarding Procedures by which Persons Receive Social Rehabilitation Services in Social Rehabilitation Institutions and Requirements for Providers of Social Rehabilitation Services, 2009. SI 2009/279. https://likumi.lv/ta/id/190188-noteikumi-par-kartibu-kada-personas-sanem-socialas-rehabilitacijas-pakalpojumus-socialas-rehabilitacijas-institucijas-un-prasib...

face to face interview with the applicant during which her/his degree of severity of the self-care, mobility and functioning disorders associated with the life at home is assessed using the Barthel Index (see Chapter Three) and social functioning problems to be addressed during social rehabilitation are identified. The office prepares an assessment report.

If necessary to make an informed decision the social service office may involve a family doctor, treating physician, an occupational therapist or physiotherapist. A service is granted if the severity of the functioning disorders according to the Barthel index is scored from 0 to 19 points. For cases that have scored up to 6 points, the decision should indicate the accompanying person and the source of financing of the expenses related to his or her stay at the social rehabilitation institution. The social service office sends the documents to SSIA.

The Chernobyl NPS accident mitigation measures participants should submit an application, a document confirming their status and a statement issued by a family doctor or a treating physician regarding the state of health of the person and the absence of medical contraindications for the receipt of the service. The social service office should decide within five working days and send the decision to SISA.

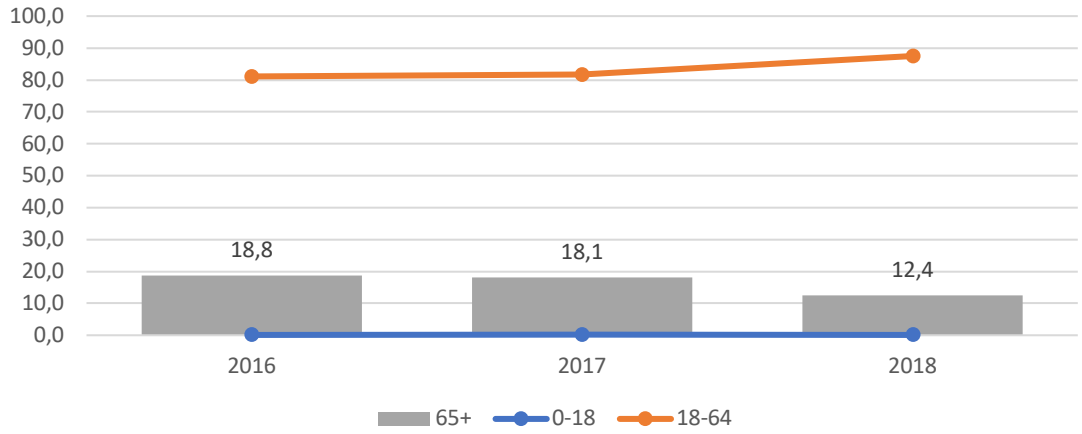
For urgent cases, the treating physician evaluates the person and provides an opinion on the need for the service. A social worker or a treating physician applies the Barthel index, identifies social functioning problems to be addressed during social rehabilitation and prepares an assessment report. These documents, an extract from medical rehabilitation treatment (or a statement from the treating physician, if a person still undergoes treatment) and the application is sent to SSIA.

Upon receipt of the documents in general cases, SISA should decide within 20 working days on granting the service or granting the service as a matter of urgency by issuing an assignment to SISA; on declining the service or on placing the admission on a waiting list (which is based on personal status, the service history and recommended duration), and informs the person and the social service office. The SISA requests information from SSIA on whether an elderly person (“after working age”) with functioning limitations is a worker or a self-employed person. If the service is requested by a person with a predictable disability, the decision should be made within five working days.

At the start of the service, the needs of a person, the severity of the functioning disorders associated with self-care and mobility are reassessed and an individual social rehabilitation plan is developed, specifying the quantity of services of a social worker, psychologist, physiotherapist and occupational therapist to be provided. Within the scope of the service, these services are also available: services of a doctor and a nurse; first medical aid at any time of the day; monitoring of the medical treatment specified by the family (treating) doctor, special dietary regime and recreational and sport activities.

Most of the social rehabilitation service beneficiaries are of working age (87.5 percent in 2018), followed by working elderly (12.4 percent). The share of children is negligible (Figure 4.25).

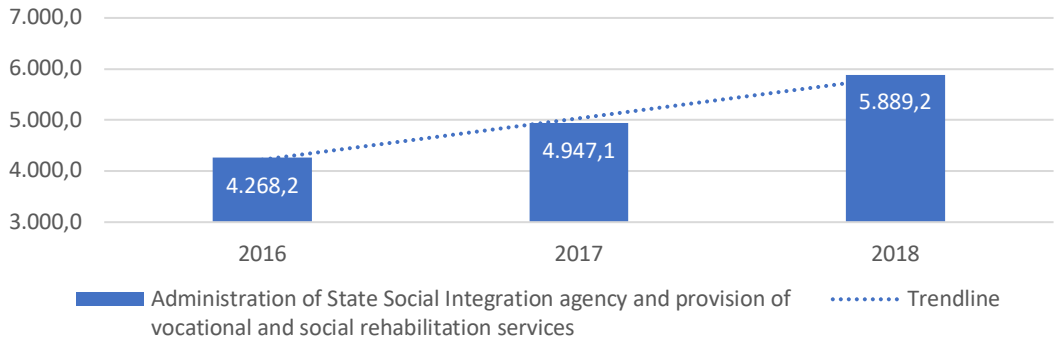
Figure 4.25 -Social rehabilitation service beneficiaries by age (%)



Source: SISA

Between 2016 and 2018 public spending SISA, including on social and vocational rehabilitation services increased 38.0 percent (Figure 4.26).

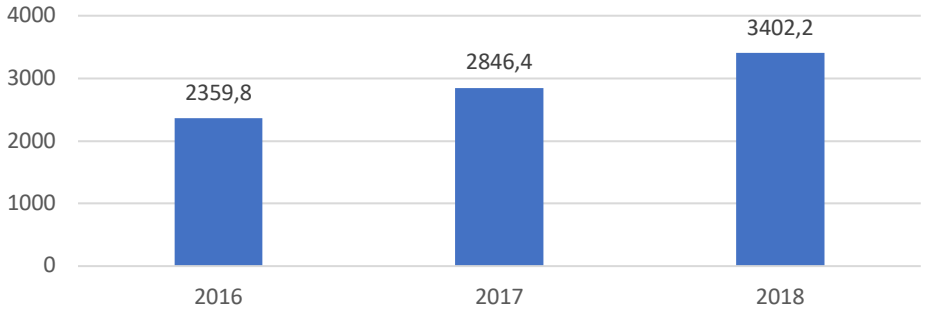
Figure 4.26 -Public spending on vocational and social rehabilitation, including SISA administrative budget (000 EUR)



Source: MOW

Within the SISA's overall budget, between 2016 and 2018 expenditure on social rehabilitation services increased by 44.2 percent (Figure 4.27) and in 2018 it constituted 58.0 percent of all SISA budget (3 percentage point up from 2016).

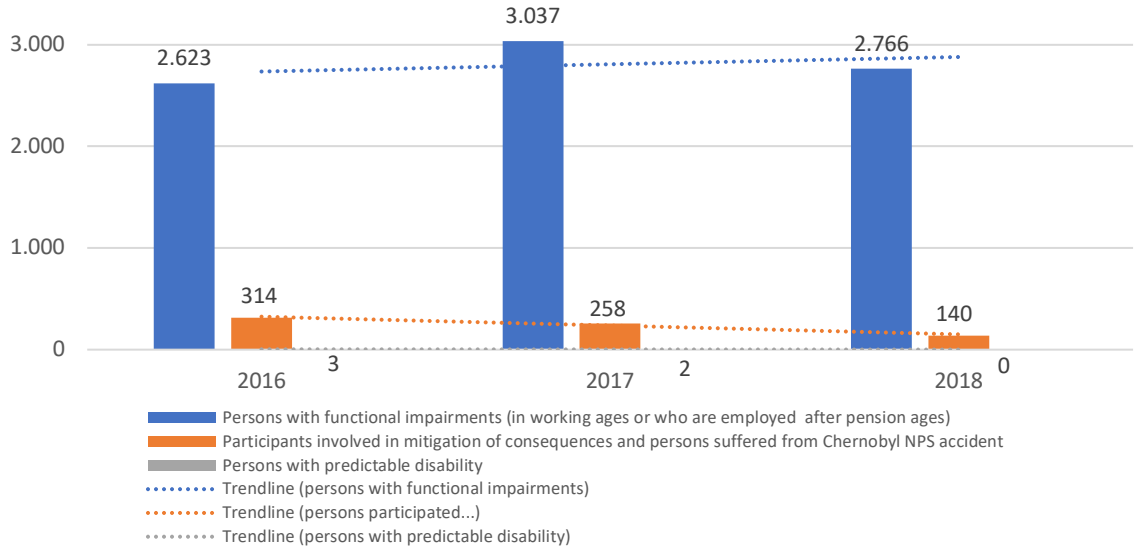
Figure 4.27 -SISA spending on social rehabilitation (000 EUR)



Source: SISA

At the same time, the number of beneficiaries slightly decreased (1.2 percent) (Figure 4.28), signaling a sharp increase in the cost per beneficiary: from EUR 803.0 to EUR 1,167 per beneficiary or 45.0 percent in just two years (almost 5 times the inflation rate).

Figure 4.28 -Number of beneficiaries of social rehabilitation service



Source: SISA

Overall, at about 3,000 beneficiaries per year, only 1.6 percent of all persons with disabilities have access to social rehabilitation services. There is no analysis of their effectiveness and efficiency and the extent to which they have contributed to better functioning and participation in social and economic life of persons who have used the service, sometimes for years. Social rehabilitation services are perceived more as a continuation of medical rehabilitation services and are often not implemented in conjunction with the services identified in the individual rehabilitation plans developed in municipalities. This perception is also reflected in the Parliament decision to expand the eligibility to persons experiencing difficulties in functioning (including predictable disability), but without SMC disability assessment and determination. What happens is that some patients who need medical rehabilitation are transferred, as a matter of urgency, to a social rehabilitation institution to undergo rehabilitation treatment. The cost of rehabilitation is transferred from the health to the welfare budget. This quick fix may not be optimal, because social rehabilitation institutions are not a replacement for proper post-acute medical rehabilitation. Moreover, for cases where social rehabilitation service is provided as a matter of urgency the relevant local government social service office may only obtain information on the service provision after SSIA has decided to award the service.

Given the overall disability policy orientation towards community-based provision of services MOW should conduct an in-depth impact assessment of this mode of service provision and consider options to transform them into out-patient community based social rehabilitation services. For groups, such as participants in the Chernobyl NPS accident impact mitigation, the service can be grandfathered, as these groups have risked their lives performing their duty.

Social rehabilitation services at the place of residence

Social rehabilitation services can be provided to a person at the place of her/his residence; in alternative (community-based) social care service institutions; day-care centers for: persons with mental disorders, children with disabilities, and persons with physical disabilities; halfway houses; and

group houses (apartments). Their provision depends on the size of local governments, financial capabilities, the extent of state support and the political will.

The services are in their infancy and, hence, it is too early to talk about the system of social rehabilitation services. Services for individuals, even with the same type of functioning limitations, are viewed separately without a harmonized approach. Within the framework of social rehabilitation services, people often ask for health care services such as dental care, medicines, medical goods, healthcare, signaling issues in access to these service within the health care system.

iv. Social rehabilitation services for persons with impaired vision and hearing

Social rehabilitation services for people with impaired vision and hearing are provided by the LSB and the LAD. Both NGOs fulfil the duties specified by the state, in accordance with the procedures laid out in the Cabinet Regulation.[176] The arrangement is based on a contractual arrangement with MOW, which supervises their performance. Social rehabilitation services are provided as a separate service or in combination with technical aids according to the nature of a person's health and functioning disorder.

To receive the service, a person must submit to the respective NGOs an application, personal identification document, and a copy of a document indicating the type of functioning impairment (disability certificate, SMC opinion, an opinion of the family doctor or a treating physician). The decision should be made within 20 working days. The NGO decision can be appealed to the Chairman of the NGO Board; the decision of the Chairman of the NGO Board can then be appealed to the court or MOW and the MOW decision can be appealed to the court.

The service included the development of an individual social rehabilitation plan, specifying the type, extent and objectives to be achieved. The service is terminated if the rehabilitation objective has been achieved; if a person submits written request for the service to be terminated; as well as in cases where a person does not comply with or violates the contract regarding the receipt of the service or has provided false information. It is also possible to suspend the service for a period of time, if there is a need for a treatment at home or hospital.

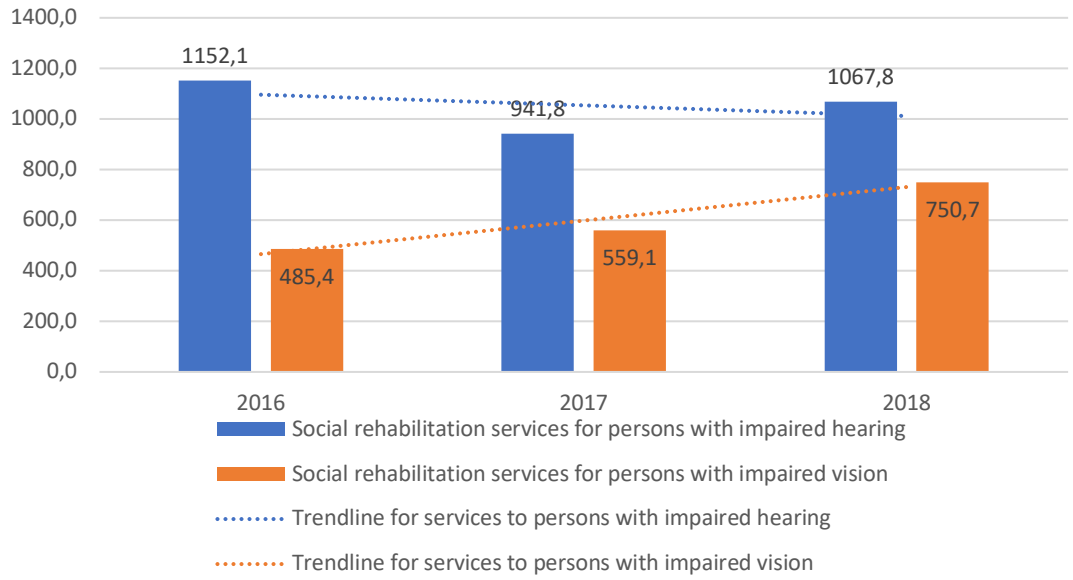
In addition, the LAD provides sign language interpretation services individually or in groups for persons with impaired hearing:

- up to 480 academic hours during one school year (in classes, consultations, seminars, examinations and other activities related to the education program) in basic vocational education, vocational secondary education and higher education institutions;
- up to 120 hours per year to ensure communication with other natural and legal persons.

The quantity of services depends on the allocated state budget. To receive the services of a sign language interpreter, a person must submit an application specifying the purpose of the service, or desired education institution and program, and the service time period. The application should be accompanied by documents attesting hearing impairment and the necessity of a service. The LAD should decide within 10 working days.

[176] Procedures for the Provision of Social Rehabilitation Services and Ensuring Technical Aids - Typhlotechnology and Surdotechnology - by the Latvian Society of the Blind and the Latvian Association of the Deaf, 1472. SI 2009/1472. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/202630-kartiba-kada-latvijas-neredzigo-biedriba-un-latvijas-nedzirdigo-savieniba-sniedz-socialas-rehabilitacijas-pakalpojumus-un-nodrosina-tehniskos-paliglidzeklus--tiflotehniku-un-surdotehniku

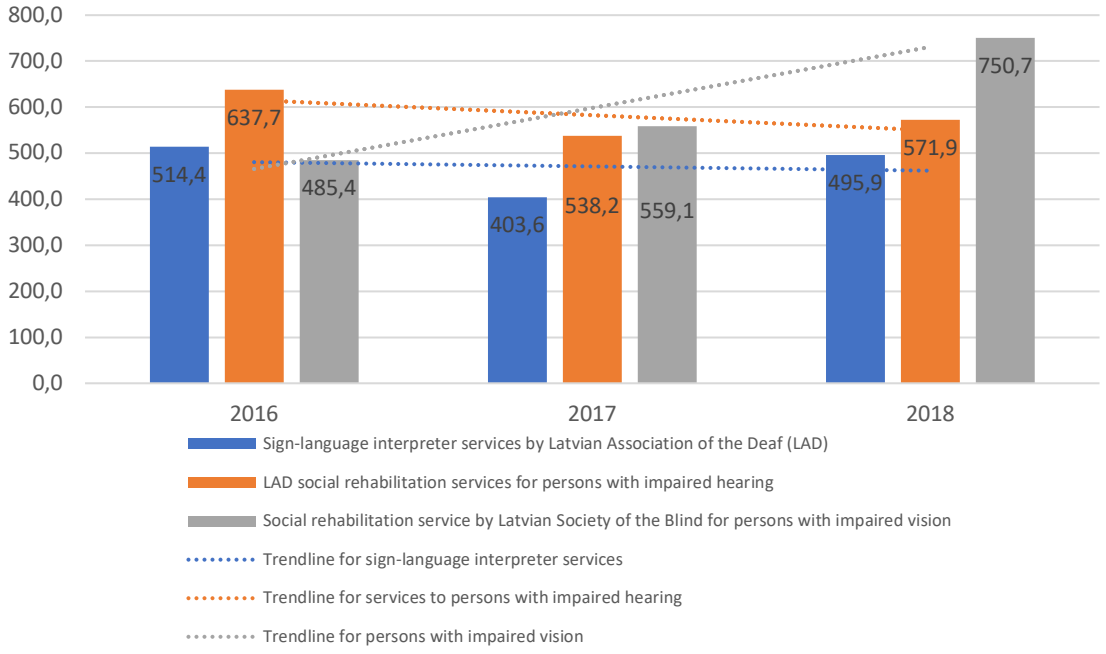
Figure 4.29 -Total expenditure on social rehabilitation services for persons with impaired hearing and vision (000 EUR)



Source: MOW

The funding (social rehabilitation and sign language interpreter services) for LAD decreased by EUR 84,300 or 7.3 percent between 2016 and 2018, while for the LSB it increased by EUR 265,300 or 54.7 (Figure 4.29). Looking at the funding by type of services, the resources for social rehabilitation services for people with impaired hearing declined by 11.0 percent (Figure 4.30).

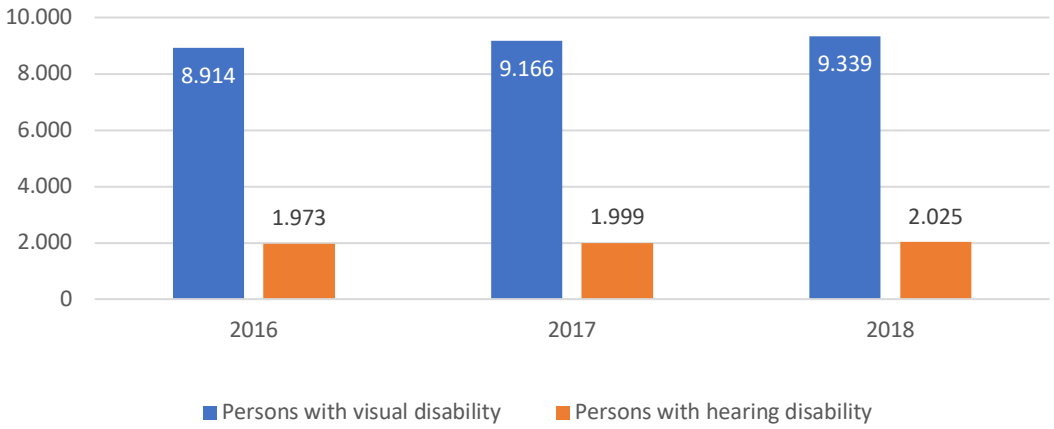
Figure 4.30 -Spending on social rehabilitation services for people with impaired vision and hearing by groups of service (000 EUR)



Source: MOW

Figure 4.31 and Table 4.20 present data on the numbers of persons with impaired vision and hearing 2016-2018.

Figure 4.31-Number of people with impaired vision and hearing



Source: MOW

Table 4.20 -Persons with impaired vision and hearing by severity of the disability

	2016	2017	2018
Total number of persons with impaired vision	8,914	9,166	9,339
Group I disability	2,614	2,685	2,736
Group II disability	2,280	2,362	2,437
Group III disability	4,020	4,119	4,166
Total number of persons with impaired hearing	1,973	1,999	2,025
Group I disability	1	1	1
Group II disability	53	51	50
Group III disability	1,919	1,947	1,974

Source: Ministry of Welfare

Given a large difference in the number of potential beneficiaries, it is hard to understand the rationale behind much larger budget allocation for services for a smaller group (persons with hearing impairments). It is puzzling that changes in budget allocation do not correlate with changes in the number of potential beneficiaries. MOF should conduct an audit of services in order to establish cost parameters for services. The service provision should be invoiced to MOW by service providers and reimbursed monthly or quarterly (up to the annual budget allocation). Administrative cost should be clearly specified in the contract. In this way, MOW would have clear information on the number, type and cost of provided services, and on the unmet demand for services which would enable it to monitor spending and make informed decisions about future budget allocation.

v. Provision of technical aids

The provision of persons with technical aids is regulated by *The Law on Social Services and Social Assistance*[177] and by pertinent Cabinet Regulations.[178]

Those eligible to receive technical aids are persons with disabilities; persons with predictable disabilities; persons for whom the technical aid is necessary to reduce or eliminate functioning limitations; and persons with anatomical defects (in case of prosthesis or orthopedic footwear). Technical aid is administered and provided by especially established company: The State Limited Liability Company "NRC "Vaivari"". Tyflotechnology and surdotechnology services are provided by LSB and LAD, respectively.

Persons with disabilities for whom SMC has determined medical indications for the purchase of a specially adjusted motor vehicle and the receipt of a compensation of transport expenses have the right to the adjustment of a vehicle from the state budget, so as to fulfil the function of a technical aid. The adjustment of vehicles belonging to disabled persons is carried out by SSIA.

Tyflotechnology is provided (manufactured, adapted, issued) for persons with impaired vision of Group III disability and blind persons. Surdotechnology is provided to persons with impaired hearing (starting from 3rd degree, hearing loss at least 55 dB, hearing loss for a child with a hearing impairment of at least 1st degree, hearing loss of at least 25 dB better in the hearing ear) and deaf persons. The list of tyflotechnology and surdotechnology provided by the state budget is approved by the Cabinet. The list includes assistive products for personal medical care, prostheses and orthoses, personal mobility aids, household aids, communication and signaling aids, as well as assistive aids for improving and evaluating the environment.

For the receipt of technical aids, persons with hearing or visual impairments should submit an application to LAD and LSB, respectively (the application could be sent by the post or electronically, as well), indicating necessary technical aid by attaching documents confirming the impairment and the need for technical aids. A decision should be made within 20 working days. In certain cases, the technical aid should be granted immediately (e.g. an eye prosthesis) or as a matter of urgency (for children under the age of one and a half). If a person wishes to obtain a technical aid of increased functionality, s/he should make a co-payment equal to the difference between the price of the technical aid and the lower price of the group of technical aids included in the list approved by the Cabinet.

For the receipt of other technical aids, a person should submit a request to the NRC "Vaivari" Technical Aids Center (Vaivari TAC) and attach necessary documents.

The application can be submitted in person, electronically or by post and should include necessary documents. The application must provide personal information, the type and purpose of the requested technical aid, information on whether the need for technical aid is related to a road accident, accident at work or occupational disease, whether the health of the person has been insured; and whether s/he wishes to purchase an aid by providing co-payment or receiving a

[177] Ibid. (s.25). https://likumi.lv/ta/id/68488-socialo-pakalpojumu-un-socialas-palidzibas-likums

[178] Rules for Technical Aids, 2009. SI 2009/1474. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/202674-tehnisko-paliglidzeklu-noteikumi and Procedures for the Provision of Social Rehabilitation Services and Ensuring Technical Aids - Typhlotechnology and Surdotechnology - by the Latvian Society of the Blind and the Latvian Association of the Deaf, 1472. SI 2009/1472. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/202630-kartiba-kada-latvijas-neredzigo-biedriba-un-latvijas-nedzirdigo-savieniba-sniedz-socialas-rehabilitacijas-pakalpojumus-un-nodrosina-tehniskos-paliglidzeklus--tiflotehniku-un-surdotehniku

reimbursement. The applicant should also attach an opinion of the treating physician, occupational therapist or physiotherapist, etc., on the need for technical aid, as well as other documents confirming the need.

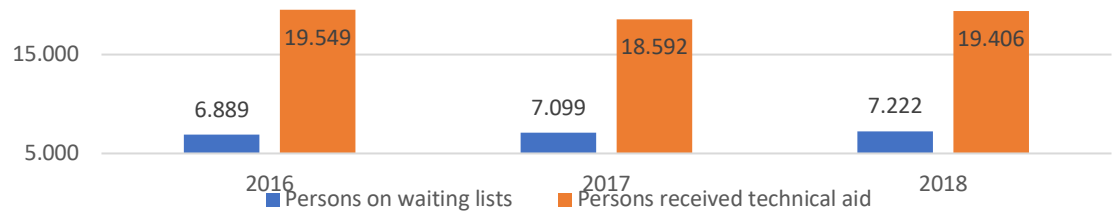
A technical aid may be obtained in timely fashion or urgently.[179] The following persons qualify for urgent procedures: persons with first-time functioning impairments, persons with a predictable disability, children, pregnant women who due to changes in anthropomorphic indicators have to replace previously received technical aids, and employed persons and persons in education, if the technical aid is needed for education or for the performance of work duties.

Vaivari TAC should decide within 20 working days. The refusal may be based on several factors, including (i) incomplete application or documents not complying with the Cabinet Regulation; (ii) the person has already borrowed the requested aid; (iii) the person has requested several technical aids which in a similar way compensate for the same functioning impairments; and (iv) the granting of the technical aid requires an opinion by the TAC Commission for the Assessment of Functioning. The Commission is held in cases of complex functioning limitations, when the type and severity of the impairments has changed; in cases of disputes where according to a person's application it is necessary to change the type of technical aid or to postpone its issuance; and to decide on granting the compensation to a person who has bought a technical aid in a Member State of the EU and the European Economic Area or in the Swiss Confederation.

The Vaivari TAC decision may be contested with the Chairman of the Board of Vaivari TAC and this decision may then be appealed to the court or MOW. MOW decision can be appealed to the court.

There is a waiting list for the receipt of many technical aids and Cabinet has set a deadline after which a person can repeatedly be put on the waiting list.[180] The purchase of individual types of wheelchairs is possible within six months of taking in a queue, but for a co-payment. In this case a person is repeatedly put on the queue after a longer period. Following the decision or the queue, Vaivari TAC invites the person to receive the technical aid at Vaivari TAC or at another service provider. If a person does not appear after a repeated call, s/he is deleted from the queue.

Figure 4.32 -Persons who have received technical aids and on waiting lists to receive them



Source: MOW

[179] To receive technical aid urgently, a person with the first-time functioning limitations should provide an extract from her/his patient medical card of in-patient or out-patient hospital, or a sheet from the hospital patient medical card with an *epicrisis* issued not later than six months before the submission of the documents; a person with a predictable disability - an individual rehabilitation plan where the need for technical aid is indicated.

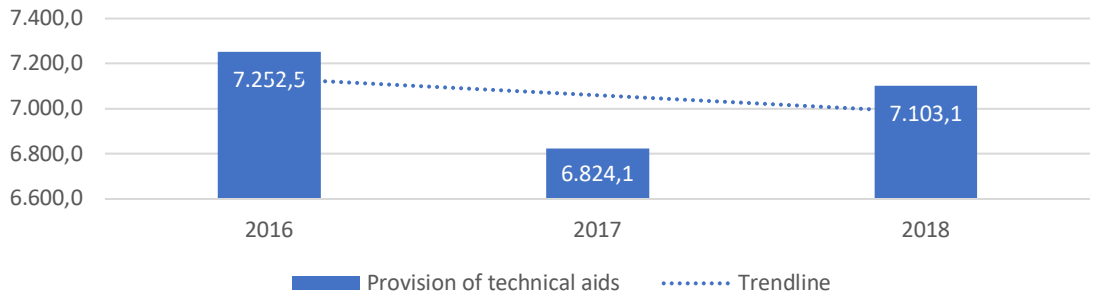
[180] A person may repeatedly be put on the waiting list if the deadline specified by the Cabinet has expired; the type and severity of the person's functioning limitations have changed and, making previously issued technical aid unsuitable; the technical aid has worn out and is suitable for further use (except if TAC has established that technical aid was intentionally damaged); the person`s anthropometric measurements have changed; and the technical aid has been lost or stolen and a person provides reasonable explanation that s/he is not to blame.

A technical aid can be given or lent to the person. In both cases a person is required to contribute a small amount (for a child EUR 1.42; for an adult EUR 7.11). The following persons are exempted from this fee: a needy person, a person who is in the long-term social care and social rehabilitation institution or whose place of residence is registered in a hospital/medical institution and prisoners. If a technical aid is to be delivered at the place of the person's residence, a person shall pay for the delivery. The technical aid that is on loan should be returned to Vaivari TAC after the expiry of the contract.

On average 19,200 people (including disabled persons) receive technical aids each year. The waiting list comprises 7,100 people. Between 2016 and 2018, a number of persons who have received technical aid slightly decreased, while the number of persons on the waiting list increased by 4.3 percent (Figure 4.32).

Total public spending on technical aid (though all providers) dropped by 6.0 percent in nominal terms between 2016 and 2017 (Figure 4.33), then increased by 4.0 percent in 2018, but was still below 2016 by 2.0 percent in nominal terms (3.0 percent in real terms). This is puzzling, given the number of people on waiting lists for technical aids.

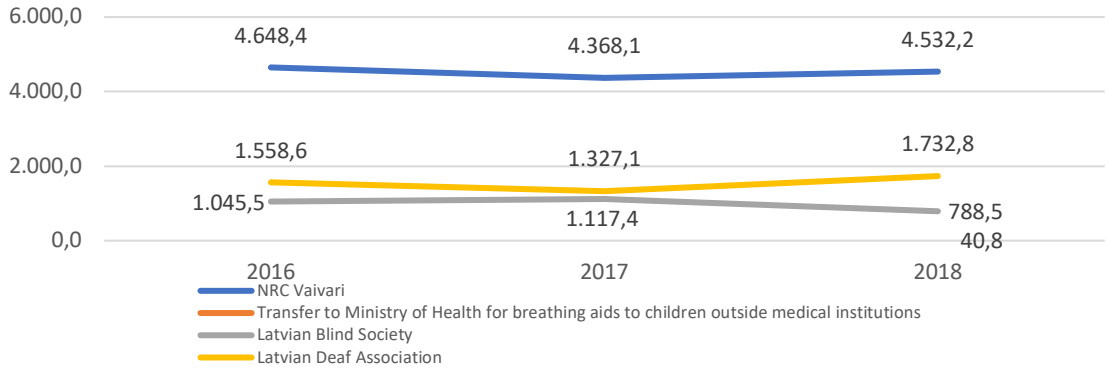
Figure 4.33 -Total public expenditure on technical aids (000 EUR)



Source: MOW

Figure 4.34 shows spending by providers. The largest provider is the Vaivari TAC through which about 64.0 percent of spending was channeled in 2018, followed by LAD with 24.4 percent and LSB – 11.1 percent. The annual trend has been volatile and unpredictable: spending through LAD for surdotechnology increased 11.2 percent between 2016 and 2018; spending through LSB for tyflotecnology decreased by 24.6 percent and spending through the Vaivari TAC dropped by 3.2 percent in nominal terms.

Figure 4.34 -Public expenditure on technical aids by provider (000 EUR)



Source: MOW

The list of publicly-provided technical aids includes personal medical care aids, orthoses, prostheses, footwear, personal care and protective equipment, personal mobility aids, assistive products for households, assistive products for adapting houses and other spaces, technical aids for communication, and technical aids for breathing. The list includes a total of 145 items, indicating for each one whether it is to be given as a loan or into property, the time at which a person may enter into queue for the re-receipt of technical aid and other conditions for the receipt (e.g., to get a functional bed on a loan a person must submit to the Vaivari TAC a Braden scale assessment indicating a high risk of pressure ulcer). The list of technical aids is not complete and does not provide for all needs of persons with disabilities in a reasonable time and appropriate to the need. Insufficient public funding results in waiting lists, forcing individuals to purchase needed technical aid.

Administrative procedures require an applicant to indicate in the application the technical aid s/he wishes to receive. Provision of technical aids is not a simple matter as they must be fit for purpose, which requires skilled professionals. But such specialists are in short supply in Latvia. Anecdotal evidence suggests that people with disabilities are not satisfied with the functioning of the Vaivari TAC noting its complex procedures, long queues, and staff attitude. A set of interviews conducted for this study on the costs of technical aids and on the methodology for setting up a more efficient and effective compensation system, showed that more than half of key informants who were interviewed were not satisfied with the functioning of the Vaivari TAC. The situation is further complicated by MOW and MOH joint oversight, which in the absence of clear division of responsibilities holds up needed changes at the Vaivari TAC.

Currently, the Vaivari TAC acts as a public purchase agency that on the account of the state procures technical aids from various providers to whom it refers applicants. New technical aid producers and providers have been established in the field of orthosis and prostheses, using new technologies and material. Orthoses and prostheses are produced for a specific individual, while procurement is dominated by criteria such as variety of technical aids to be manufactured. Several service providers are contracted, and the person can choose one of them. But it is hard to make an informed choice, as it is not clear from provided information whether a particular service provider in reality specializes in the manufacturing of specified technical aid. For mobility and care aids Vaivari TAC uses intermediaries. Consequently, instead of individualized technical aids, so called “base models” are offered. The use of intermediaries not only increases the cost of technical aids provision, but also results in sub-standard services, as the beneficiaries do not get the technical aid that they need.

Technical aids are one of the key pillars of disability policies aimed at optimizing functioning. Their importance is only going to increase with technological advancements and aging of the population. Good quality, reasonably priced and fit for purpose aids are crucial for improved quality of life and activities and participation of many persons with disability. Furthermore, the provision of many technical aids should be integrated into the process of medical rehabilitation. While many devices may be available off the shelf, in many cases they need to be tailored to the person’s needs. A good example is a wheelchair: to serve its purpose a wheelchair must to be fitted to a person who is going to use it. A poorly fitted wheelchair can cause health problems such as pressure sores, for example. Moreover, a person needs to be trained on how to use it.

The technical aid provision in Latvia seems to be in need of significant restructuring: from administrative process, quality of services, a much more important role played by rehabilitation and technical aids specialists, to business processes and customer service management to reporting, monitoring and evaluation, for improved efficiency and effectiveness. Based on a series of interviews with key stakeholders, conducted for the purpose of this study, the following short- to medium-term policy actions have emerged:

- Conduct an in-depth review and audit of technical aids services, including beneficiary feedback.

- Strengthen the quality of provided services, including through significantly improved human resources.
- Strengthen the Government's role in the provision of technical aids by clearly defining policy development, implementation and reporting and monitoring responsibilities of MOW and MOH.
- Secure adequate quality of services, the provision of technical aid devices, such as orthoses and prostheses, individually produced technical aids, respiratory technical aids, and others that require customization and close monitoring by medical and rehabilitation professionals. These services, moreover, should be integrated into the medical rehabilitation process and, thus transferred to the MOH responsibility and financing. Services could be provided in multi-profile hospitals of regional importance and medical rehabilitation institutions.
- The provision of other technical aids, such as personal care and protection and some mobility aids, i.e. industrial technical aids, could remain under MOW responsibility with the Vaivari TAC as an implementation agency under MOW.
- Move to the principle of reimbursement with contractors, whereby provided aid expenditure is reimbursed based on detailed information about beneficiaries, details about the technical aid that was provided, the cost and the information on the provider. This would also enable monitoring of the provided services.
- Improve record keeping and reporting with precise information on each beneficiary, technical aid provided and its cost. Compile information on demand for technical aids from people on the waiting list. Use this information to plan service provision and budget.
- Review, streamline and tighten procurement requirements.
- Plan the budget based on evidence about the demand.
- Increase the range of technical aid that would be provided under public funding.
- Consider introducing co-pay with exemptions and depending on the income of the beneficiary.
- Increase human resource capacity of the Vaivari TAC staff to increase the quality of services it provides.
- Increase collaboration between the Vaivari TAC and social service offices of local governments in order to ensure timely and high-quality service appropriate to person`s individual needs.

vi. Psychosocial rehabilitation

The amendments to the *Law on Social Services and Social Assistance* in 2017[181] introduced psychosocial rehabilitation. Persons with a predictable or first-time disability caused by an oncological disease, a relative, and a child in palliative care are entitled to psychosocial rehabilitation.

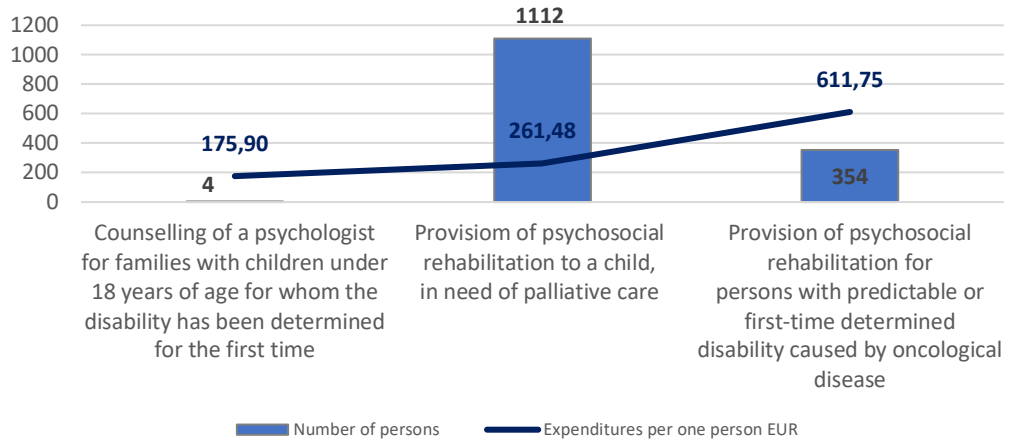
In cases of oncological disease, psychosocial rehabilitation is provided in accordance with the opinion of a family doctor and an individual rehabilitation plan, and the service is provided by the Society "Dzīvības koks". In 2018, 354 people with oncological disease and their relatives received services. The expenditure was EUR 240,620. Since 10.0 percent of the budget is allocated to the service administration, the cost per beneficiary was EUR 611.75. Psychosocial rehabilitation for a child in palliative care and members of his or her family is provided by the Children`s Palliative Care Society. In 2018, 289 children in palliative care and their 823 relatives received services. The budget was EUR 323,067 and the cost per beneficiary excluding administrative cost was EUR 261.48 (Figure 4.35).

The Disability Law[182] entitles children whose disability has been determined for the first time and who live with their family, as well as their legal representatives to receive services of a psychologist funded

[181] Amendments to the Law on Social Services and Social Assistance in 2017. Riga: Saeima. Available at: https://likumi.lv/ta/id/288297-grozijumi-socialo-pakalpojumu-un-socialas-palidzibas-likuma
[182] Ibid. s. 12 (1) 8). https://likumi.lv/doc.php?id=211494

from the state budget. This service is provided by local government. The service is costed at EUR 17.59 per session (or EUR 175.90 per beneficiary).

Figure 4.35 -Psychosocial services: number of beneficiaries and the cost per beneficiary, 2018



Source: MOW

vii. Vocational rehabilitation

The Law on Social Services and Social Assistance defines vocational rehabilitation as "a set of measures that following an individualized assessment of functional disorders and determination of vocational suitability to ensures the attainment of new occupation, vocational knowledge or skills or renewal thereof, including a vocational education program at basic and secondary education level and multidisciplinary services for integration into the labor market for persons of working age".[183] The services are provided by SISA. SISA: (i) provides vocational rehabilitation services and determines vocational suitability for persons of working age with disability, mental impairments, or predictable disability; (ii) provides driving lessons and (iii) determines vocational suitability for unemployed persons who have been unemployed for at least for 12 months and have received a referral from the Public Employment Service (PES) – see Annex 10; and provides vocational rehabilitation services to persons with mental impairments to whom disability or predictable disability has not been determined.

The procedure to receive vocational rehabilitation services is determined by the Cabinet Regulations.[184] Working age persons with disabilities or predictable disability can benefit from it during the period of disability specified by the SMC. The service is provided in two stages: determination of vocational suitability and implementation of the rehabilitation program.

To have vocational suitability determined, a person must apply to SISA and provide the following documents: copies of education and qualification documents and either a copy of an individual rehabilitation plan issued by a treating physician or a copy of an individual rehabilitation plan approved by SMC, if the person has predictable disability. In addition, the person needs an opinion from the family doctor specifying primary and secondary diagnoses in ICD-10 codes and confirmation that there

[183] Ibid. (s.1, s.15[1], s.26 (2). https://likumi.lv/ta/id/68488-socialo-pakalpojumu-un-socialas-palidzibas-likums

[184] Procedure by which Persons Receive State Financed Vocational Rehabilitation Services and a Service of Vocational Suitability Determination, 2017. SI 2017/94. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/288897-kartiba-kada-persona-sanem-valsts-finansetus-profesionalas-rehabilitacijas-pakalpojumus-un-profesiaonalas-piemerotibas-noteiksan...

are no medical counterindications, or else a referral from the PES to perform the determination of vocational suitability.

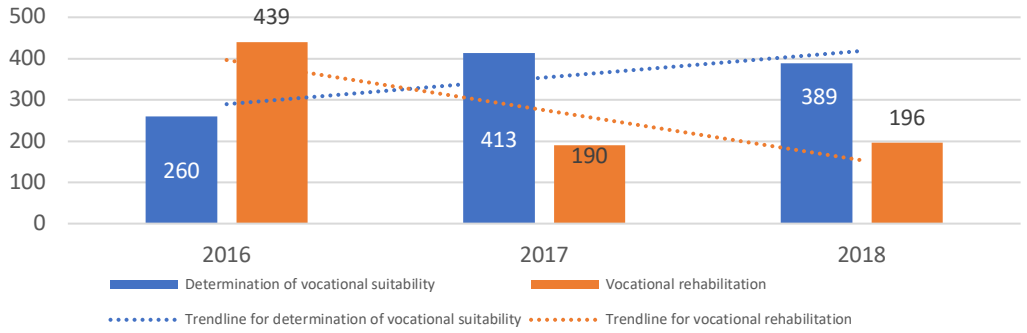
During the determination of the vocational suitability the person's education, functioning limitations, social skills, abilities and motivation must be taken into account. This phase can last up to 10 days during which a vocational rehabilitation program is developed, including necessary support measures to integrate a person into the labor market. SISA must decide about vocational suitability within a month after having received an application. Once it does, SSIA decides whether to grant the request or not, and if granted issues recommendations to PES, employers and other institutions regarding the necessary support measures for the integration of a person into the labor market. These measures include the adaptation of the workplace and technical aids; working arrangements and working environment; description in the individual rehabilitation of working ability to be renewed and improvement (or the appropriate field of professional activity for the person).

A person whose request for vocation rehabilitation has been approved must report to SISA to sign a contract specifying conditions for vocational rehabilitation, the rights and duties of the person, etc. As part of the service, an individual social rehabilitation plan with medical elements is developed and may include: a skills acquisition program or motivation strengthening program; the acquisition of vocational education to be acquired at the Jurmala city vocational secondary school or college; an individual social rehabilitation to renew work capacity; training to develop personal self-care skills; support for traineeship or apprenticeship placement; support for finding employment: individual consultations at work place and recommendations for the adaptation of the workplace; and driving lessons. The duration of the vocational rehabilitation service depends on the duration of the vocational training program.

In the Jurmala Vocational Secondary School, the following courses are provided:

- vocational basic education: computer use;
- vocational initial education program: Commercial sciences, Technology for manufacturing tufted products, Metalwork;
- vocational secondary education programs: Computer systems, databases and computer networks, Catering services, Commercial sciences;
- vocational in-service training programs: Material manufacturing technologies and manufacturing of products;
- vocational further education programs: – Housekeeping, Catering services, Computer use, Computer systems, databases and computer networks, Electrical equipment.

Figure 4.36 -SISA vocational rehabilitation; number of beneficiaries

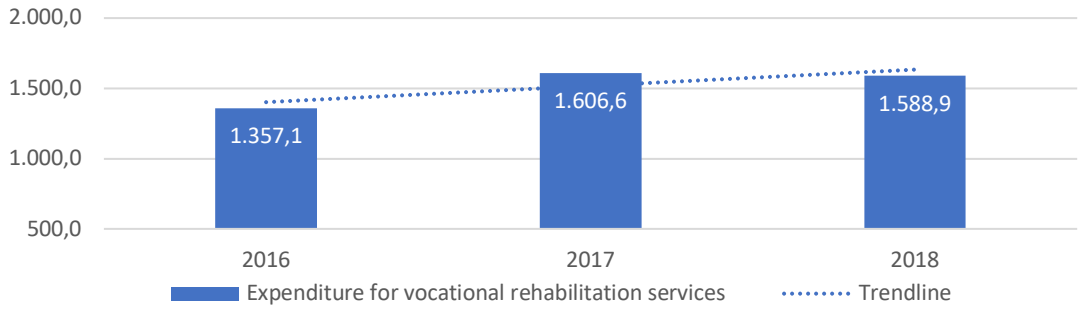


Source: SISA

The Jurmala College offers first level higher vocational education in the following programs: Human Resource Management, Accounting and Taxes, Marketing and Trade, Hotel Service Management, Information Technology, Applied Systems Software and Sign Language Interpretation.

During the determination of vocational suitability and vocational rehabilitation, SISA also provides three meals a day according to the person's diet and state of health; accommodation in the service hotel; and transport from the service hotel to the place where services are provided, sport and social inclusion activities.

Figure 4.37 -SSIA expenditure on vocational rehabilitation (000 EUR)

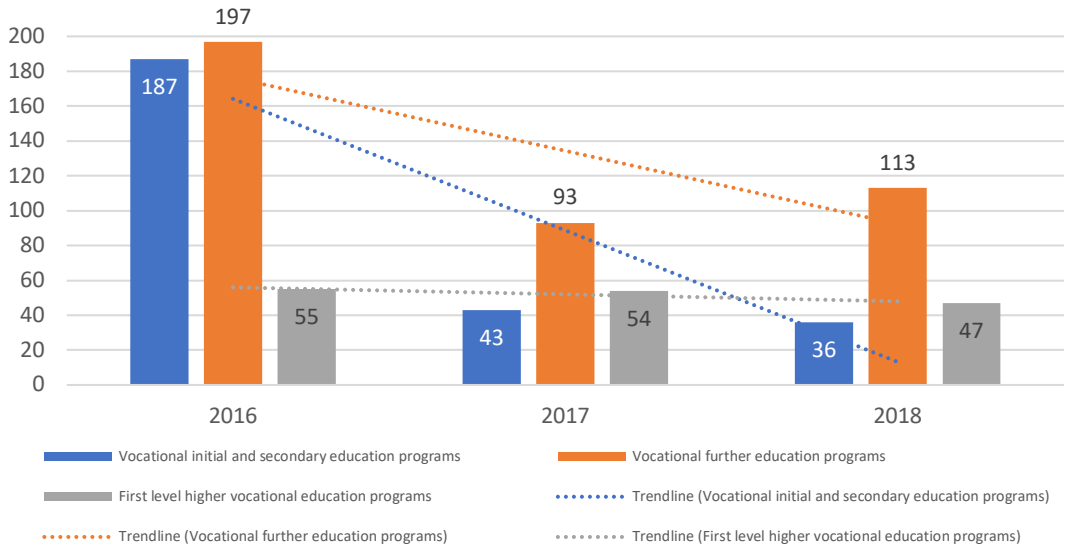


Source: SISA

Figures 4.36 and 4.37 provide data on the beneficiaries and public spending on vocational rehabilitation. 2016-2018. The number of persons benefiting from vocational rehabilitation is small: 439 in 2016 and 196 in 2018 (a 55.3 percent decline). The number of people whose vocational suitability was determined increased from 260 to 289 (49.6 percent) in the same period. The total number of beneficiaries decreased from 699 in 2016 to 585 in 2018 ((16.3 percent). At the same time, SISA expenditure on vocational education increased by 17.1 percent, resulting in the increase in the per beneficiary cost from EUR 1941.5 to EUR 2,716 (40.0 percent) in just two years.

Most of the beneficiaries, attend “further” vocational education programs (Figure 4.38).

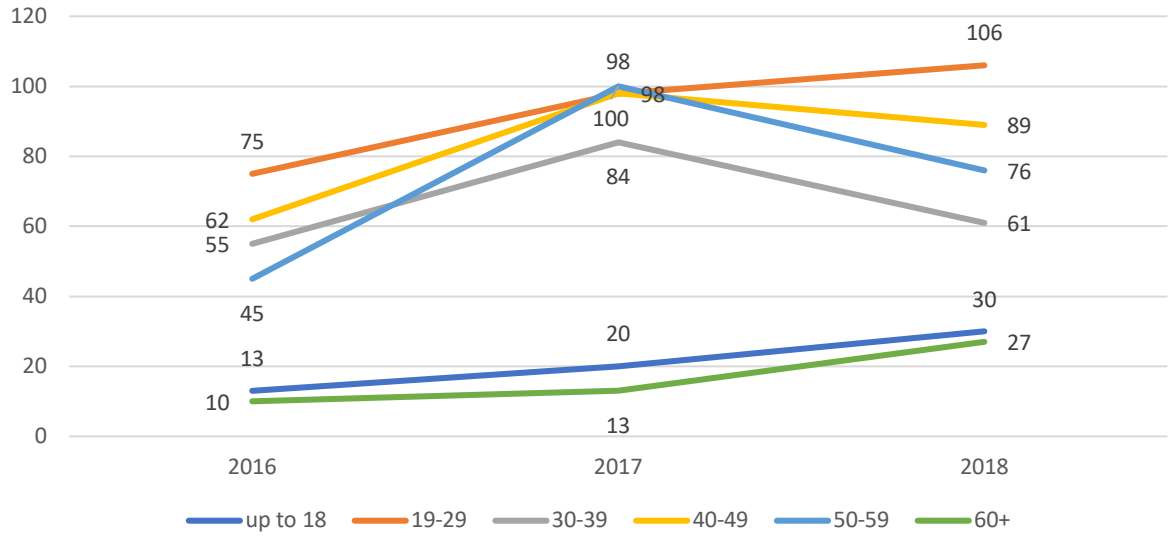
Figure 4.38 -SISA vocational rehabilitation reprogram recipients by program



Source: SISA

Most of the 389 beneficiaries whose vocational suitability was determined in 2018 belonged to the 19-29-year age cohort (27.2 percent), followed by 40-49 years group (22.9 percent) and 50-59 percent (19.5 percent) (Figure 4.39).

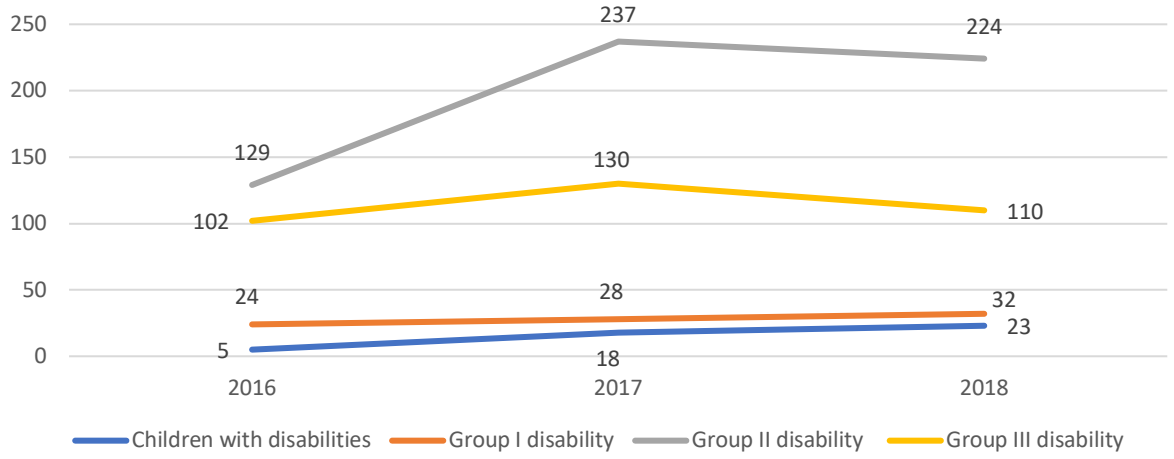
Figure 4.39 -SISA - determination of vocational suitability, beneficiaries by age



Source: SISA

Group II (57.6 percent) and Group III (28.3 percent) persons with disabilities dominate (Figure 4.40).

Figure 4.40 -SISA - determination of vocational suitability, beneficiaries by disability group



Source: SISA

The data presented above suggest that vocational rehabilitation in Latvia is severely underdeveloped and underutilized as a policy instrument. Vocational rehabilitation can play an important role in keeping persons experiencing disability at work. There is no reason why employed persons experiencing disability should not continue working. To facilitate this an assessment of vocational suitability during the sick leave and prior to having her/his disability assessed by SMC would be very beneficial. PES, local social service office, and others should give the person an opportunity to continue working where possible. Waiting until after the person has left the labor market, as evidenced by very low number of beneficiaries, is in most cases too late. There is sound evidence that people who leave

employment after having been assessed as having a disability, rarely come back to the labor market. Latvia should therefore reconsider its model of vocational rehabilitation, reorienting it towards ex-ante (before leaving work), instead of ex post action (after having left employment into disability pension). It should also rethink whether the current model of Jurmala center, boarding school type of vocational education could be replaced by training and education provided by vocational schools and other training centers across the country.

A separate issue is vocational rehabilitation of young people with disabilities – for this group an inclusive education system that has an emphasis on education and training within the mainstream education should be pursued as a matter of principle.

4.2.5 Medical rehabilitation

i. An overview

The Medical Treatment Law,[185] defines medical rehabilitation as the field of medicine that deals with the development of physical, psychological, social, vocational and educational development of a person, according to his/her physiological and anatomical limitations or, in case of stable health disorders, with environmental and social adaptation to patient's life. The aim of medical rehabilitation is to provide services that reduce or prevent restrictions of functioning for persons who experience these restrictions, as well as assess the risk of complications, prevent and reduce them. The organization and financing of medical rehabilitation is defined by the Cabinet Regulation.[186]

Referral of patients to medical rehabilitation services is performed by: (i) physical and rehabilitation medicine (PRM) doctors who consult patients in acute care setting or, if patients are treated in out-patient care setting, consult the patient by examining the person or assessing the referral of another doctor or medical documentation prepared by a specialist in functioning; (ii) psychiatrists or pediatric psychiatrists, in case of psychiatric disorder; (iii) narcologists, in cases of substance abuse disorders; (iv) primary care physicians, in cases where patients have restriction in functioning and rehabilitation services delivered by the so called "functioning specialists"[187] in no more than five consultations.

Medical rehabilitation is delivered by physical and rehabilitation medicine doctors (or a psychiatrist, pediatric psychiatrist or narcologist, when appropriate) and the functioning specialists, in the form of consultations, and mono-professional or multi-professional rehabilitation services.[188]

[185] The Medical Treatment Law 1997. https://likumi.lv/doc.php?id=44108

[186] Government of Latvia. (1997, 06 12). Ārtsniecības likums (Medical Treatment Law). Retrieved 10 15, 2019, from https://likumi.lv/doc.php?id=44108

[187] According to The Medical Treatment Law, functioning specialists are physiotherapists, occupational therapists, technical orthopedists (Orthotic and Prosthetic Specialists), speech and language therapists, nutrition specialists and art therapists. Ibid. *from https://likumi.lv/doc.php?id=44108*.

[188] Cabinet regulation No. 555. 2018: Procedures for organization and payment of health care services. https://likumi.lv/ta/id/301399-veselibas-aprupes-

Photo credit: SSIA

Mono-professional medical rehabilitation service is rehabilitation service delivered by single PRM doctor (or psychiatrist, pediatric psychiatrist or narcologist, when appropriate) or a specialist in functioning. It can be part of acute care, acute rehabilitation service or ambulatory (outpatient) service, for the provision of which other medical practitioners and medical support persons may be attracted and which is provided on an outpatient or inpatient basis within the scope of acute rehabilitation.

Multi-professional medical rehabilitation service is a specialized form of medical rehabilitation delivered by multi-professional rehabilitation teams at in-patient (day hospital) or out-patient rehabilitation institutions. For this form of rehabilitation, service is delivered by a PRM doctors (or psychiatrist, pediatric psychiatrist or narcologist, when appropriate), a specialist in functioning and with participation of medical practitioners and medical support personel, as well as clinical or health psychologists. Professionals involved in the team are selected based on the patient's condition. The team is coordinated by a PRM doctor (or psychiatrist, pediatric psychiatrist or narcologist, when appropriate). Based on the intensity of rehabilitation, there are two forms of multi-professional rehabilitation: (i) a basic rehabilitation service – two to three hours per day that includes patient's individual work with functioning specialists, using at least three different medical technologies;[189] and (ii) an intensive rehabilitation service – three to four hours a day of functioning specialist's individual work with patients, using at least three different medical technologies. Once a week, the rehabilitation team meetings is organized, and the decisions made are documented.

[189] Medical technologies are methods and devices that are used in the treatment and registered in the Database of Medical Technologies that are used in the Treatment. The State Agency of Medicines. Data base of medical technology used in treatment. *https://www.zva.gov.lv/zvais/mtdb/*

Prioritization of patients for medical rehabilitation is conducted in the following way:

1. Persons with acute and subacute limitations in functioning that manifests as difficulties in communication, cognition, movement, selfcare and instrumental activities of daily living;
2. Persons with subacute limitations in functioning that affects the person's ability to work or can be a cause of disability;
3. Persons with chronic limitations in functioning in time intervals, specified in the rehabilitation plan, if a person is under dynamic observation;
4. Other persons with limitations in functioning.

Children up to three years and with high risk of developing limitations in functioning, children three to six years of age with severe and moderately severe limitations in functioning and employees of crisis or first respondent government services, whose health has been damaged due to participation in rescue operations in emergency or catastrophe situations with more than five victims, receive rehabilitation services on a priority basis.

ii. Types of medical rehabilitation services in Latvia

The following types of medical rehabilitation are provided: (i) acute rehabilitation; (ii) post-acute rehabilitation; and (iii) long-term rehabilitation.

Acute rehabilitation is delivered in acute care hospitals, up to three months from the beginning of the treatment after the onset or worsening of the disease. Medical institutions are mandated to provide consultation of PRM doctor for all patients who are discharged from acute care hospital (i.e. an inpatient medical treatment institution) after the treatment of cerebrovascular disease for assessment of rehabilitation needs. If the person requires further rehabilitation, a PRM doctor prepares a rehabilitation plan and issues a referral for further rehabilitation. Before a discharge from the hospital, all patients with restrictions in functioning must be assessed for rehabilitation needs by a PRM doctor, rehabilitation plan should be prepared and a referral to further rehabilitation issued. If the hospital does not employ a PRM doctor, the attending doctor must prepare recommendations for further rehabilitation needs and describe rehabilitations services provided in the hospital.

Post-acute rehabilitation - delivered up to six months from the beginning of the treatment after the onset or worsening of the disease. It can be organized as in-patient rehabilitation, out-patient rehabilitation (day rehabilitation and ambulatory rehabilitation), long-term rehabilitation and at home rehabilitation.

- *In-patient rehabilitation*: basic or high intensity multi-professional and multi-disciplinary rehabilitation service; attending doctor is a PRM doctor that lasts up to 6 months from the onset of the disease. Programs include post-acute rehabilitation for adults; post-acute rehabilitation for children; long-term rehabilitation and dynamic observation for adults; long-term rehabilitation and dynamic observation for children; rehabilitation for health conditions of perinatal period (up to 1 year of age); rehabilitation for patients with spinal cord injury and medical rehabilitation for patients with need long-term mechanical ventilation.
- *Out-patient rehabilitation:* (i) Day rehabilitation – multi-professional basic or high intensity rehabilitation service; (ii) Ambulatory rehabilitation - mono-professional low intensity rehabilitation service close to the patient's place of residence.
- *Long-term rehabilitation services* are provided in case of chronic limitations of functioning, if the rehabilitation services are needed more than 6 months from the onset of the disease or in the case of perinatal disorders; patients are included in the follow up register for a dynamic observation of medical rehabilitation. Each facility where rehabilitation services are provided

keeps separate records of the dynamic observation of medical rehabilitation, which includes results of the functioning assessment and results of rehabilitation.

Rehabilitation at home is provided by certified physiotherapist, occupational therapist or speech and language therapist for the following patient groups: (i) patients with spinal cord injury; (ii) persons with cerebrovascular diseases – if the rehabilitation has started not later than 3 months after the onset of the disease; it can be continued for no longer than 6 months after the onset; (iii) children registered with the palliative care consulting room of the Children's Clinical University Hospital.

One treatment episode of home rehabilitation services cannot exceed 60 days (6 months for persons with spinal cord injury). If there is need for further rehabilitation services at home, PRM doctor should give a referral to continue with home rehabilitation program.[190]

iii. Capacity to meet the demand

In 2017, the State Audit Office of the Republic of Latvia performed an audit of the state funded medical rehabilitation services in Latvia[191] with several recommendations on how to improve the service. In response, MOH had agreed with the State Audit Office on the timetable for the implementation of the recommendations and has implemented a series of measures to address them (see Box 4.1).

The audit report showed that working age adults (18-59 years of age) represent only one third of persons who received medical rehabilitation treatment in 2016 (Table 4.21), concluding that rehabilitation services for patients of working age are not provided in timely manner and to the required extent.[192]

Table 4.21- Beneficiaries of medical rehabilitation financed the National Health Service (NHS) 2015-2017 (first semester)

Year	2015			2016			2017 (first half)		
	Total number	18-59 years of age	%	Total number	18-59 years of age	%	Total number	18-59 years of age	%
Day rehabilitation	8,210	3,199	40	6,049	3,511	58	5,574	2,206	40
Ambulatory rehabilitation	72,353	23,508	33	72,786	23,074	32	46,586	14,885	32
Home rehabilitation	1,317	196	15	1,267	193	15	820	102	12
In-patient rehabilitation	4,932	1,599	32	5,012	1,614	32	5,154	1,641	32

Source: The State Audit Office of the Republic of Latvia.

[190] Amendment to the Cabinet regulation 555. https://likumi.lv/ta/id/301399-veselibas-aprupes-pakalpojumu-organizesanas-un-samaksas-kartiba

[191] The report: "Is medical rehabilitation provided to patients who need it and at the right time?" was published in 2018. Latvijas Republikas Valsts kontrole. Revīzijas ziņojums. Vai medicīniskā rehabilitācija tiek sniegta pacientiem, kam tā ir vajadzīga un pareizajā laikā? Rīga, 2018.
http://www.lrvk.gov.lv/uploads/reviziju-zinojumi/2016/2.4.1-44_2016/Revizijas%20zinojums_Mediciniska%20rehabilitacija_07122018.pdf

[192] Ibid.

The audit reported that only 10.0 percent of working age adults who have been on a sick leave and receiving sickness benefit have received medical rehabilitation services (Table 4.22). This signals that sick leave in Latvia is not used as an opportunity to optimize functioning of persons who may experience disability and may apply for disability assessment after the sick leave has expired (in Latvia about 20,000 people apply annually to SMC to have their disability assessed for the first time). In some ways, this appears consistent with the overall traditional tilt of disability policy, where support and rehabilitation measures are employed only after a person has been formally certified as disabled. The interactional view of disability (see Chapter Three and Annex 1) calls for a different approach, one focused on optimizing functioning to maximize activities and participation of persons experiencing disability.

Table 4.22 -Working age adult on a sick leave and those who have received medical rehabilitation services financed by NHS

Year'	Total number	Who have received medical rehabilitation	%
2015	98,616	9,570	10
2016	107,995	9,945	9
2017 (first 6 months)	65,851	6,287	10

Source: The State Audit Office of the Republic of Latvia.

The audit report also noted the lack of information on the demand for rehabilitation services.[193] There is no systematic evaluation of the quality of rehabilitation processes in Latvia either.

Since there is no information on the demand for rehabilitation services, it is difficult to draw conclusions about human recourses. However, long and increasing waiting lists for rehabilitation services signal significant and growing unmet demand, on the one hand, and the shortage of staff and insufficient resources, on the other. The State Audit report noted that the waiting lists were not getting shorter. For instance, the waiting list for the ambulatory physiotherapy services at the Children's University Hospital increased from 111 to 368 days between January 2017 and November 2018. At the National Rehabilitation Centre (NRC) "Vaivari", the waiting period increased from 30 to 120 days. Similar trends were reported in other facilities providing outpatient physiotherapy services. The waiting period for day rehabilitation services reportedly can reach as long as 375 days. Available data on in-patient rehabilitation shows that on October 1, 2019 the longest waiting period for individual adult rehabilitation programs at the NRC "Vaivari" was up to 24 weeks; for children, however, it was only 2 to 4 weeks, and for persons with spinal cord injury 2 weeks. Out of 9 other facilities where rehabilitation services are provided, only two reported waiting lists of 6 weeks (the East University Hospital) and 8 weeks (Vidzemes Regional Hospital).[194]

[193] Ibid.

[194] http://www.vmnvd.gov.lv/lv/veselibas-aprupes-pakalpojumi/stacionaro-pakalpojumu-gaidisanas-rindas

Box 4.1 - MOH actions in response to the State Audit Service Report recommendations

To address concerns raised in the State Aidit Service report “Is medical rehabilitation provided to patients who need it and at the right time? published in 2018, MOH has undertaken the following action thus far:

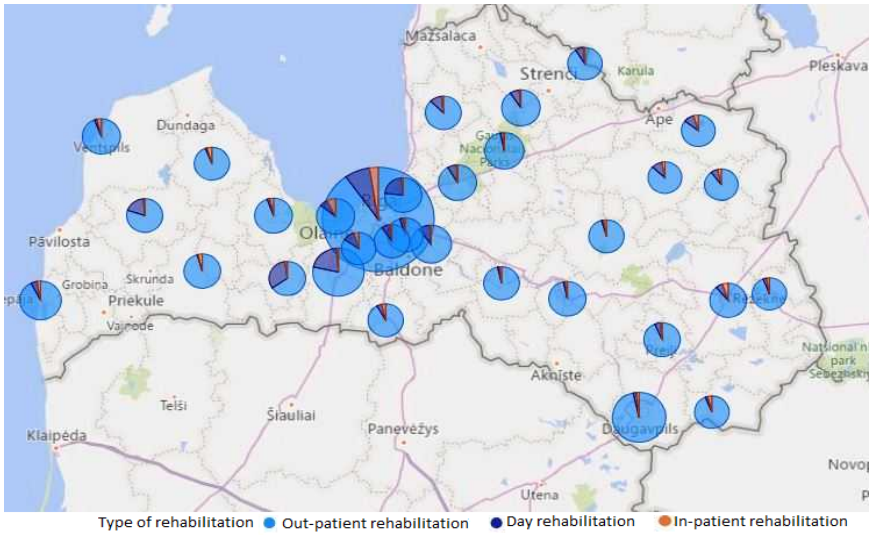
- A new payment model for inpatient rehabilitation services was developed, bringing the state payment closer to the actual cost of rehabilitation. It is thus asserted that inadequate payment for rehabilitation services should not be a reason for the termination of the rehabilitation process without achieving the defined rehabilitation goals;
- Within the framework of the “Clinical Methodological Management Project”, the project “Functioning Assessment Protocols for Certain Groups of Patients in Rehabilitation Practice” is currently being developed. Its aim is to develop a common approach to documenting the rehabilitation process based on scientific evidence. Both short- and long-trem benefits are expected: documentation of the rehabilitation process, data collection, evaluation of the rehabilitation process, and improvements. To date, the protocols for the specialists in functioning have been developed for patients with lower extremity amputation and for patients after te stroke;
- As of January 1, 2020, NHS has included a clause in its agreements with medical institutions, which provides criteria for referring patients to social rehabilitation. Patients who have received 24-hour inpatient second-stage medical rehabilitation services and are in need of social rehabilitation after having been released from the hospital are referred to social rehabilitation services. The objective is to ensure that medical and social rehabilitation do not overlap, but are successive;
- In October 2017, the European Union Fund project “Improvements in the qualification of the medical and medical support staff” No. 9.2.6.0 / 17 / I / 001 was launched. The project offers an opportunity to medical practitioners, medical support personel, pharmaceutical service providers and the social sector professionals to supplement their professional and general knowledge through the ESF-funded training. Family physucians also have an opportunity to attend training and acquire knowledge on rehabilitation as part of their professional development. An example of such training is a course entitled: "Early recognition of functioning impairments to reduce or prevent possible disability in newborn and children with impairments at high risk of disability";
- In order to improve information base for statistical analysis and research on the observed fast increase in disability and incapacity for work in the population, a cooperation and data exchange agreement was concluded between the Latvian Centre for Disease Prevention and Control, the NHS, the State Emergency Medical Service of Latvia, the Health Inspectorate and SMC. The participants also agreed to provide data to to the “Latvian health and healthcare indicators database” maintained by the Latvian Centre for Disease Prevention and Control. In 2021 and annually thereafter, SMC will provide data for the above mentioned database, thus ensuring mutual cooperation and wider data analyses opportunities, including an analysis of the increase in the incapacity for work and disability.

Source of information: MOH

iv. Spatial coverage

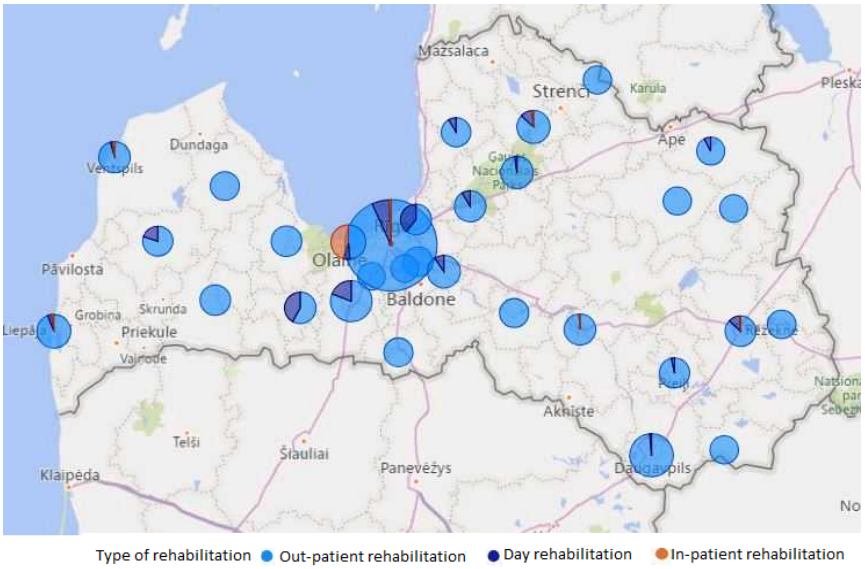
According to the data of the National Health Service, in 8 months since the reform of the organization of rehabilitation services in April 1, 2019, there were 3,813 patients in in-patient rehabilitation; 12,605 in day rehabilitation and 144,129 mono-professional episodes of ambulatory rehabilitation services. Figure 4.41 shows shares of persons who have received rehabilitation services by their registered place of living by planning regions. Figure 4.42 shows spatial coverage of rehabilitation services by planning regions. The figures show uneven geographical coverage of rehabilitation services, with the Riga Region having, for instance, more than half of specialists who provide state funded services of ambulatory rehabilitation. Other four regions of Latvia have considerably less professionals and the least number of specialists work in the Latgale region (Figure 4.43).

Figure 4.41- Persons who have received rehabilitation services: spatial distribution (April-December 2019)



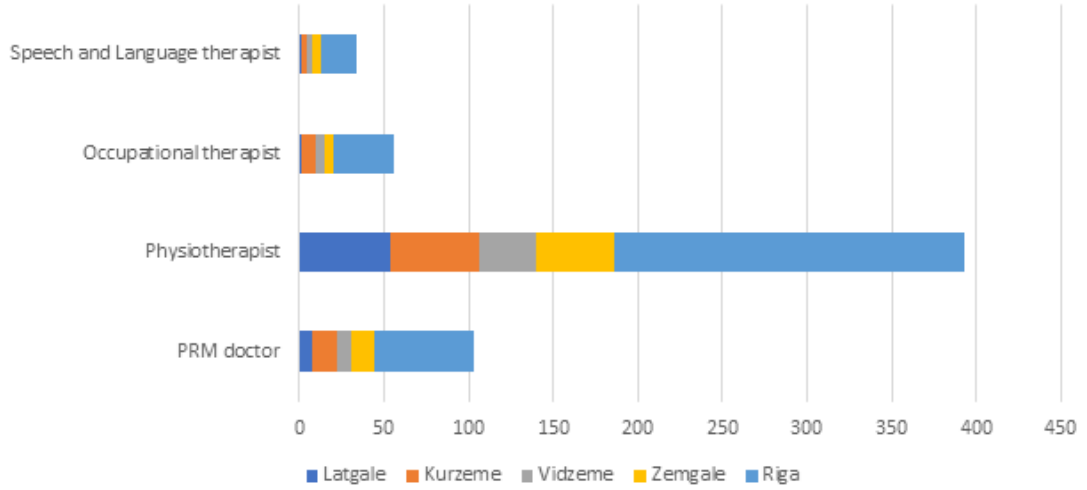
Source: NHS

Figure 4.42 -Spatial coverage of rehabilitation services by planning region



Source: NHS

Figure 4.43 -Regional distribution of rehabilitation specialists (2017)



Source: NHS

The State Audit report also noted a wide regional variation in planned funding for medical rehabilitation per 10,000 inhabitants in 2016 (Table 4.23): for ambulatory rehabilitation funding was between EUR 30,150 in the Latgale Region and EUR 17,290 in the Kurzeme Region and for day rehabilitation between EUR 55,0001 in the Zemgale Region and 4,471 in the Vidzeme Region. While a proper analysis of spending would require the number of cases and types of services, the variation is so large that it would be useful to conduct a review of parameters used to plan spending.

Table 4.23-Planned funding for medical rehabilitation per10,000 inhabitants in 2016 by region (in EUR)

	Ambulatory rehabilitation	Day rehabilitation
Riga region	28,067	15,638
Kurzeme region	17,290	9,805
Latgale region	30,150	12,805
Vidzeme region	18,706	9,471
Zemgale region	27,770	55,001

Source: The State Audit Office of the Republic of Latvia.

v. Number of organizations providing medical rehabilitation

The number of organizations providing different types of rehabilitation services in Latvia is presented in Table 4.24. Until April 2019, there was no separate funding for rehabilitation services in the acute care hospitals, so there is no information on the services delivered before. These services are provided in three University hospitals in Latvia (Children's Clinical University Hospital, Pauls Stradiņš Clinical University Hospital and Riga East University Hospitals), 7 regional and 7 local hospitals, as well as 2 hospitals specialized in traumatology.

The main medical institutions that provides in-patient rehabilitation (post-acute and follow up) is NRC "Vaivari", that is the only national rehabilitation center in Latvia. It provides rehabilitation for more than 80.0 percent of all patients who receives in-patient medical rehabilitation. There are also two university hospitals, two hospitals, specialized in traumatology and five regional hospitals that provide in-patient rehabilitation services.

Table 4.24 - Number of organizations providing medical rehabilitation in Latvia

Type of medical rehabilitation	Number of organizations
1. Acute rehabilitation	19
2. Post-acute rehabilitation	
2.1. In-patient rehabilitation	10
2.2. Out-patient rehabilitation	
2.2.1. Ambulatory	
2.2.1.1. PRM doctor	83
2.2.1.2. Physiotherapy	90
2.2.1.3. Occupational therapy	50
2.2.1.4. Speech and Language therapy	37
2.2.2. Day rehabilitation	29
2.3. At-home rehabilitation	53

Source: NHS

vi. Human resource in medical rehabilitation

The number of certified rehabilitation specialists is presented in Table 4.25. No conclusions can be drawn whether the resources are adequate, as there is no data on the demand for services. However, as noted, long waiting lists suggest the shortage of human resources.

Table 4.25 -Number of certified rehabilitation specialist, who are employed by institutions that has agreement with the NHS on provision of rehabilitation services

	2015	2016	2017	2019
PRM doctor	99	102	103	98
Physiotherapist	349	365	393	546
Occupational therapist	63	62	56	83
Speech and Language therapist	29	36	34	59

Source: The State Audit Office of the Republic of Latvia.

vii. Financing and resources spent on rehabilitation

Public spending on medical rehabilitation is very low. In 2017, only EUR 15.58 million or 0.06 percent of GDP was spent on this important service (Table 4.26). While the spending increased in 2015 and 2016, in 2017 it remained almost the same as in 2016. According to data from the State Audit report, in 2016, there were 107,995 persons who received medical rehabilitation treatment. Public spending for medical rehabilitation in that year was EUR 15.09 million or about EUR 140 per patient. Comparing this number with the cost per beneficiary of some other services provided to persons with disabilities, it appears the either the medical rehabilitation is very cheap in Latvia; or it is underpriced severely; or the data may not be accurate.

Table 4.26 -Public spending on medical rehabilitation 2014-2018 (EUR million)

	2014	**2015**	**2016**	**2017**
In-patient rehabilitation	3.04	4.29	4.63	4.60
Outpatient rehabilitation - ambulatory	4.66	4.89	5.47	5.55
Outpatient rehabilitation – day rehabilitation	3.43	3.75	4.18	4.56
Home rehabilitation	0.73	0.84	0.81	0.87
Total	11.86	13.77	15.09	15.58

Source: The State Audit Office of the Republic of Latvia.

(v) The role of medical rehabilitation in disability assessment

During the disability assessment process (see Chapter Three), a PRM doctor, who decides on referral of patients to medical rehabilitation, assesses and determines and documents: (i) the health condition and related limitations in functioning; (ii) potential for medical rehabilitation; (iii) motivation of the person and his/her relatives; (iv) whether the health condition is stable enough for participation in rehabilitation; (v) optimal type of rehabilitation services.

The PRM doctor is also responsible for the development of the individual rehabilitation plan, which must include the following information: (i) an assessment of limitations in functioning and activities and participation; (ii) the aim of medical rehabilitation; (iii) type of planned rehabilitation service; (iv) professionals that are planned to be involved in the rehabilitation and goals that are expected to be reached; (v) necessary technical aids; and (vi) intensity of planned medical rehabilitation.

Currently, the assessment of functioning is documented only in the patient's medical chart, either on paper or in the local electronic system of the rehabilitation facility. There is no common data collection system, therefore, the transmission of the assessment between facilities or services cannot be provided in proper way. There is no agreement on the common standards of assessment of functioning and goal setting in rehabilitation, therefore, the quality of documentation varies between professionals.[195]

[195] According to the Cabinet Regulations, the competence of medical practitioners and students in the first and second level professional higher medical education programs and the scope of their theoretical and practical knowledge, any person who has acquired doctor's degree, must have theoretical knowledge and practical skills in assessment of functioning of patients and general knowledge in technologies used in physical and rehabilitation medicine. Doctors in physical and rehabilitation medicine must have detailed knowledge on functioning and its evaluation and assessment according to the ICF, including

viii. Medical rehabilitation: a summary of key findings and recommendations

Thought this section, we have discussed the issues and what could possibly be done to address them, in order to improve the extent and efficiency and effectiveness of medical rehabilitation in Latvia. As noted, medical rehabilitation is key to optimizing functioning of persons experiencing disability and maximizing their activities and participation, including in the labor market. We also note that MOH has been taking actions to address recommendations from the State Audit Service Report (Box 4.1). However, the time is needed to assess the results of these actions.

- Medical rehabilitation in Latvia is underfunded and underdeveloped, as evidenced by long waiting lists for services.
- It is not well integrated into the overall continuum of the measures to maximize functioning of persons experiencing disability.
- The content and outcomes of services are yet to be defined (and standardized).
- The assessment of functioning is documented only on the patient's medical chart, either on paper or local MIS/IT system of the rehabilitation facility. There is no agreement on the common standards for the assessment of functioning and goal setting in rehabilitation, therefore, the quality of documentation vary, thus affecting the overall rehabilitation process, as well as disability assessment.
- Primary care physicians and PRM physicians are the key persons for referrals to rehabilitation services; they are also the link between medical and social services. They are directly responsible for optimizing functioning. However, primary care physicians are not trained to recognize the risks of disability and available rehabilitation services, with the results that referral for rehabilitation in broader terms and as regards disability prevention may not be conducted properly in addition to poor availability of these services in the health sector.
- Systemic evaluation of the quality and outcomes of rehabilitation processes is lacking and there is no information on the type, extent and quality of available service, which is needed for appropriate referrals.
- There is no data collection system that would allow an analysis of the continuum of rehabilitation or of the collaboration between social, health and vocational rehabilitation services and active labour market policies and their individual and overall outcomes.
- Medical rehabilitation for working age adults is not provided in a timely manner and appropriate and sufficient quantity.
- There are no specified rehabilitation programs for persons with health conditions that may affect their work capacity.
- The coverage of rehabilitations services is uneven across Latvia, affecting equality in access to services.

Key recommendations:

- Increase the importance of medical rehabilitation in the overall continuum of the health care provision.
- Expand and strengthen medical rehabilitation services: in terms of special coverage, menu of services, human resources and funding.
- Define content and outcomes of medical rehabilitation services (i.e. set standards).

assessment tools for this evaluation. See: Cabinet Regulation No. 268 from March 2009: "Regulations Regarding the Competence of Medical Practitioners and Students Acquiring First or Second Level Professional Higher Medical Education Programs in Medical Practice and the Level of Theoretical and Practical Knowledge of These Persons". https://likumi.lv/ta/id/190610-noteikumi-par-arstniecibas-personu-un-studejoso-kuri-apgust-pirma-vai-otra-limena-profesionalas-augstakas-mediciniskas-izglitib...

- The content and outcomes of services should be synchronised along the continuum of all rehabilitation services: from medical to social system to occupational. In other words, Latvia should build and integrated rehabilitation provision system with clear objective of maximizing functioning and activities and participation of persons experiencing disability.
- Introduce common standards of assessment of functioning and goal setting in rehabilitation.
- Simple roadmaps of pathways to services for persons with disabilities should be provided for primary care physicians and other professionals providing services for persons with disabilities.
- Systemic and comprehensive data collection system should be introduced, enabling an analysis of outcomes and learning lessons on what works and what can be done better to reduce limitations in functioning, as well as an assessment of the demands for these services.
- Rehabilitation services should be prioritized and organized in a way that promotes stay or early return to work for persons in working age.
- Develop specific rehabilitation programmes for persons with health conditions that may adversely affect their work capacity.
- Improve awareness of patients and professionals on the importance and available rehabilitation services in Latvia.

Support to persons with disabilities: key findings and recommendations

In this Chapter, we discuss publicly funded support for persons with disabilities in Latvia extended through both benefits in cash (both social security related and as state allowances), and services, ranging from social care to medical rehabilitation. In each of the relevant sections, based on the description of programs and administrative data, we draw conclusions or "findings" and recommend some actions. In this section we conclude the Chapter by providing findings and recommendations pertaining to the support to persons with disabilities overall.

Findings

Latvia features a comprehensive array of support measures to persons with disabilities, from social insurance, to state allowances to services. Almost all persons with disabilities receive at least one form of support. Social insurance programs dominate (disability pension and benefits in case of work accident or occupational disease), followed by a menu of state allowances in cash to assist with transport expenses, social care, services of an assistant, sign language interpretations, etc. Benefits in cash dominate. Social care services are nascent and provided to a small fraction of persons with disabilities. Here, Institutional (residential) forms of care are prevalent and community-based care is only at the very beginning of its development. Vocational rehabilitation and medical rehabilitation services are limited as is the provision of technical aids.

Spending on disability benefits is low and Latvia has one of the lowest spending relative to GDP of EU countries. Low spending implies low benefits. The benefits in cash are almost uniformly low, except for benefits in case of work accident and occupational disease. There are no indexation rules, and some benefits have stayed unchanged for years. Access to services like medical and vocational rehabilitation and technical aids is rationed through long waiting times.

The benefit levels seem to be a function of allocated budget rather than some **established** ***methodology with benchmarks***. It is difficult to understand the differentiation of benefits according to the severity of disability. The difference between a disability pension and compensation for lost work capacity in case of work accident or occupational disease is likely based on considerations other than contributions paid and actuarial fairness. While a focus on benefits in cash is understandable, limited provision of services calls for a hard look at the composition of support measures. Also, the demand for some benefits (e.g. benefits in case of accidents, services of an assistant) has recently

increased significantly, which calls for a closer scrutiny to understand the reasons behind the spike in demand.

Latvia does not have an established holistic method and process to assess the needs of persons with disabilities. Except in the case of three benefits for which an opinion of SMC is required, the benefits and services applied for is a decision of the person, once certified as disabled. This approach works in favor of those who are better informed and are determined to collect all necessary medical documents associated with the application for various opinions of SMC and benefits.

To access disability benefits, a person must be certified as disabled. However, if the objective of disability policy is to optimize functioning and ensure labor force participation, many benefits should also be provided prior to the certification, including medical and vocational rehabilitation, labor market programs (see next Chapter), and assistive and technical aids. Latvia has good sick leave provisions and sick leave, especially the extended period after the first 26 weeks could be used for interventions to prevent or reduce disability. To reduce disability, however, the sequence of support measures provision would need to be rethought.

Despite having an array of disability benefits, these benefits do not form a continuous range of programs that are focused on optimizing functioning and maximizing the performance of activities and participation. The brief overview of disability support measures in this chapter gives the impression of certain fragmentation rather than coherence. Many state cash allowances seem to be geared towards material support – an allowance for care, an allowance for transport expenses, etc. A different approach would be to first increase the level of a disability pension (and the state social security benefit), which is currently very low and then provide a supplement that would reflect the costs of living with disability to provide for the needs of a person. This approach, however, would require a different needs assessment and a new sequencing of support measures and disability certification. Structural imbalances are obvious, especially concerning services, which are underdeveloped and dominated by institutional care.

An integrated disability information system is lacking. There is no information system that would allow MOW to monitor benefits provided to persons with disabilities by each individual. SSIA has its own system, which includes social insurance and state allowances. But information related to the provision of services is lacking. Latvia is small and creating such a system should not be a problem. It would require collating information from various sources, and not building a new structure. Such a data base - *Welfare Information System* is hosted by MOW and SSIA, it stores data from PES, SMC local governments, etc. and should be further developed.

The practice of systematic impact assessments and evaluations is yet to be adopted. Any program should be subject to a periodical systematic impact assessment to inform the program adjustments. Programs not meeting their objectives should be discontinued.

Recommendations

Conduct a thorough review of all disability support measures irrespective of who provides them. The review should include program objectives, implementation arrangements, beneficiaries, spending, and performance in terms of achieving the objective. It should serve to identify gaps in support measures and identify options for a more cost-effective support to persons with disabilities. Our brief review shows that some programs serve a small number of beneficiaries at high average cost. The review should indicate whether it is cost-effective to keep, to discontinue or transform them. Another issue where the review would be helpful is to identify programs with similar objectives -- e.g., material orin cash support to persons with disabilities -- and consider consolidating them into one program. It goes without saying that the new benefit should be at least equal to the sum of benefits consolidated

into it. The review, which by definition would need to be multisectoral and multi-stakeholder, should provide empirical evidence to draw a disability support measures development roadmap and an action plan.

Introduce comprehensive needs assessment. Disability is a journey during which there are many opportunities to act to prevent or reduce its impact to optimize functioning and enhance the performance of activities and participation. To intervene in a timely and appropriate manner a comprehensive needs assessment is needed. One can broadly identify two phases in a disability journey: (i) pre-disability certification; and (ii) post disability certification. The first would normally start with a post-acute phase of an illness, trauma or injury. It is an opportunity to provide medical rehabilitation, technical aids, vocational rehabilitation, discuss with the employer (in case of employed individuals) options to accommodate the workplace and/or provide different job placement, etc. The needs assessment (for employed individuals) could, for instance, be conducted when a person comes to SMC for an extension of a sick leave. The objective of this phase is to undertake all available actions to facilitate recovery and optimize functioning, including support for continued employment. Phase two would comprise measures to support a person after s/he has been certified as disabled. They may include a continuation of medical rehabilitation, support services, or social insurance benefits. The needs assessment should be an integral part of the disability certification process. Both assessments should be multisectoral, with participation of relevant experts and should include not only the assessment of needs, but also the matching with available services and a referral to them. France is a good example of a comprehensive needs assessment conducted jointly with the disability assessment.

Strengthen social care and rehabilitation services. Medical rehabilitation, vocational rehabilitation and social care services are all in need of significant development and strengthening. As is the provision of technical and assistive aids. A concerted effort is needed to develop community-based social care services. Latvia needs to deinstitutionalize its care services. The process of deinstitutionalization is not simple, and it may take time to be completed, but it can be achieved, with a good plan, persistence and adequate resources to develop alternative, community-based services.

Focus disability policy, institutions and support measures on optimizing functioning, and enhancing the performance of activities and participation to improve well-being. Latvia has all the elements for effective support to persons with disabilities, although some of these elements are better developed than others. Reorienting the system towards a continuum of support, from the inception of a health condition that may result in disability, through to disability certification and support onwards would not be an insurmountable task, although it may take some time to be planned and implemented.

Improve data system: Information on individuals at risk of or experiencing disability should be available to relevant institutions implementing disability policy and programs, as well as to persons themselves. It is particularly important that information on assessments and services provided and received is recorded for better monitoring and planning, but also to ensure that persons with disabilities benefit from all support measures available to them.

Introduce periodic impact assessments and evaluations. All programs and institutions implementing them should be comprehensively reviewed periodically. Likewise, it is advisable that piloting be done prior to new programs being rolled out.

5. LABOR MARKET AND PERSONS WITH DISABILITIES

In this Chapter we present data on labor market participation of persons with disabilities and describe and discuss policies and programs aimed at fostering it (see also Annex 11 to this Report).

Photo credit: SSIA

5.1 Labor market participation of persons with disabilities

5.1.1 Employment

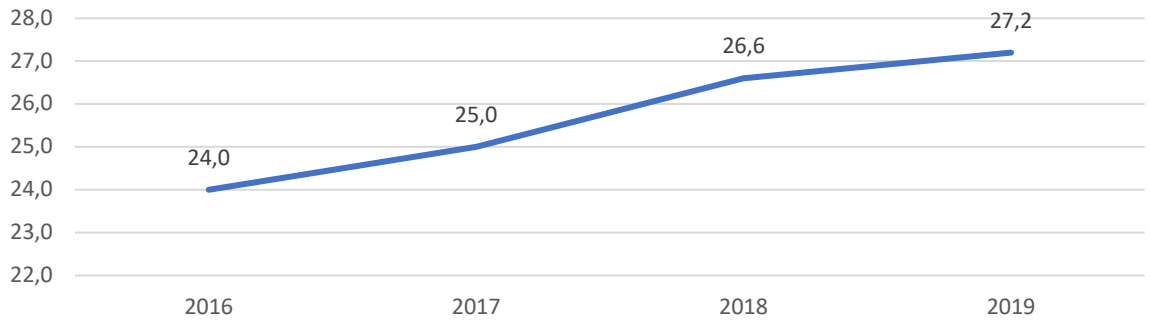
According to administrative data from SSIA, the percent of adults with disabilities identified by SSIA as employed persons[196] increased by 3.2 percent between 2016 and 2019. The number of employed persons with disabilities increased from 44,205 persons in 2016 to 49,507 in 2018. This represents 24.0 percent in 2016, 26.6 percent in 2018 and 27.2 percent of the total number of adults with disabilities, likely reflecting improved economic conditions (Figure 5.1). This is, however, less than half of the employment-to-population ratio for the general population (including persons with disabilities) of 57.4 percent in 2019.

If the employment rate is calculated only among the recipients of the disability pension and the state social security benefit, excluding persons with disability in retirement age, then 38.2 percent were

[196] According to SSIA, a person is considered employed, if she or he was self-employed or in the status of an employee even for one day during the reporting period.

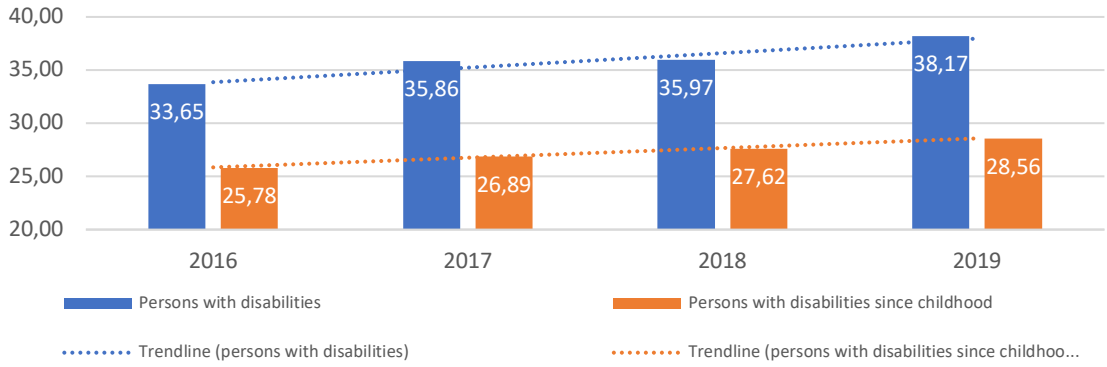
employed. Among persons who have been disabled since childhood and were receiving a disability pension or a state social security benefit this rate was 28.6 (Figures 5.2 and 5.3).

Figure 5.1 -Percentage of employed persons with disabilities
(% of the total number of adults with disabilities)



Source: MOW and SSIA

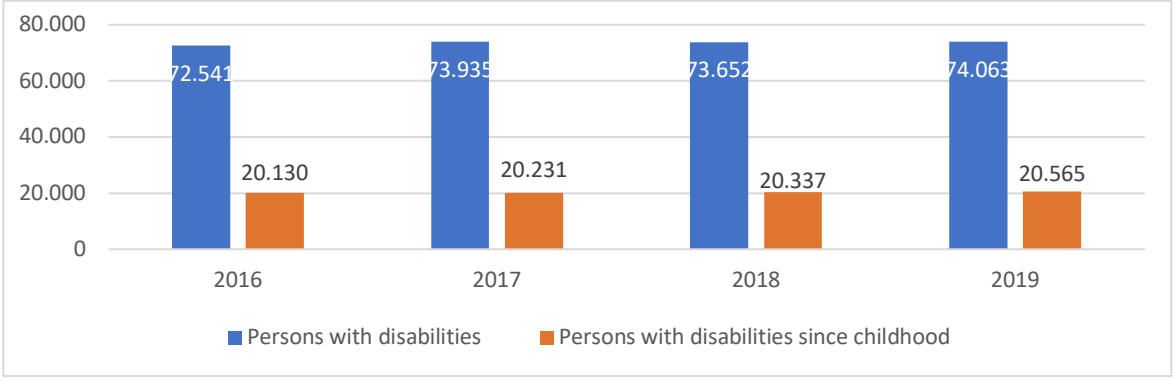
Figure 5.2 - Employed persons with disabilities aged 18 to retirement age in the number of beneficiaries of disability pension and state social security benefit of the same age (%) *



Source: SSIA, data at the beginning of the year.

**Excluding persons with disabilities beneficiaries of old age pension.*

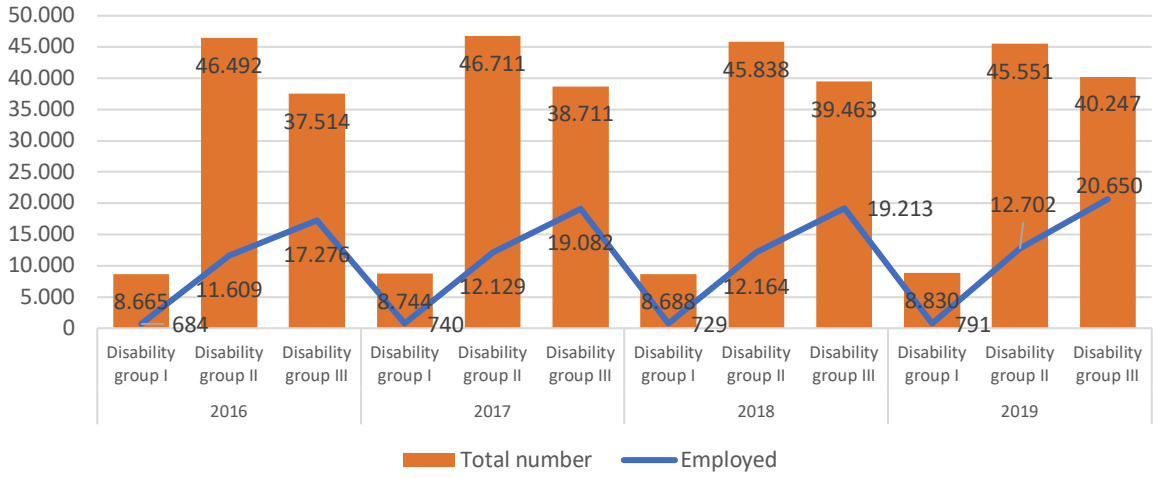
Figure 5.3 -Employed persons with disabilities aged 18 to retirement age among beneficiaries of disability pension and state social security benefit (absolute numbers)



Source: SSIA, data at the beginning of the year.
**Excluding persons with disabilities beneficiaries of old age pension.*

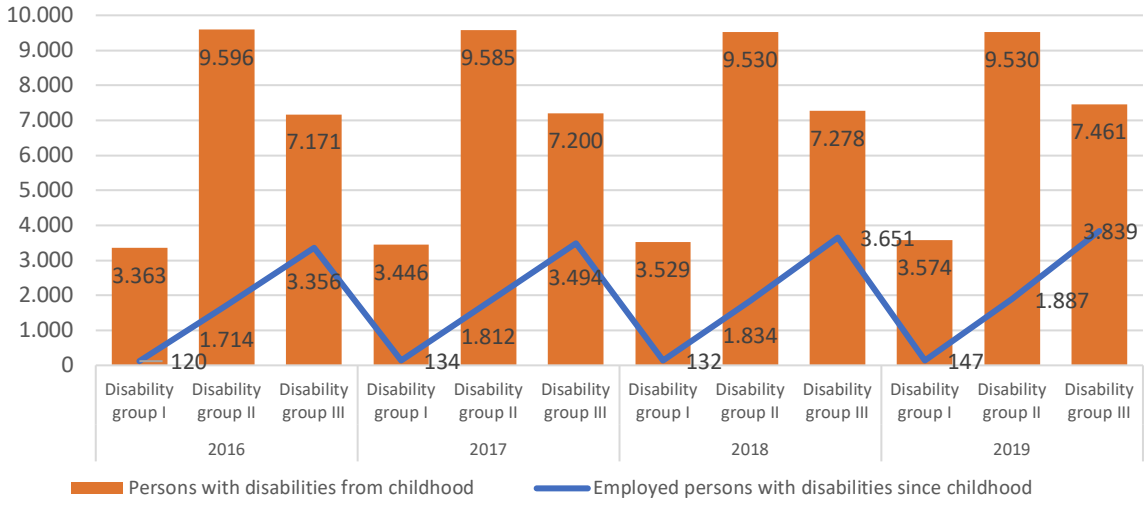
As presented in figures 5.4 and 5.5, employment varies by severity of disability. Overall, between 2016 and 2019, the number of employed persons with disabilities 18 to 63 years of age who were beneficiaries of disability pension and state social security benefit (excluding persons with disabilities beneficiaries of the old age pension) increased by 4,574 persons (from 29,569 in 2016 to 34,143 in 2019 or 4.17 percent (Figure 5.4). The highest increase was in the Group III Disability (5.26 percent); it was 1.07 percent for Group I and 2.92 percent for Group II.

Figure 5.4 -Employed persons with disabilities (18 to retirement age) in the number of beneficiaries of disability pension and state social security benefit by severity of disability 2016-2019*



Source: SSIA, data at the beginning of the year.
**Excluding persons with disabilities beneficiaries of old age pension.*

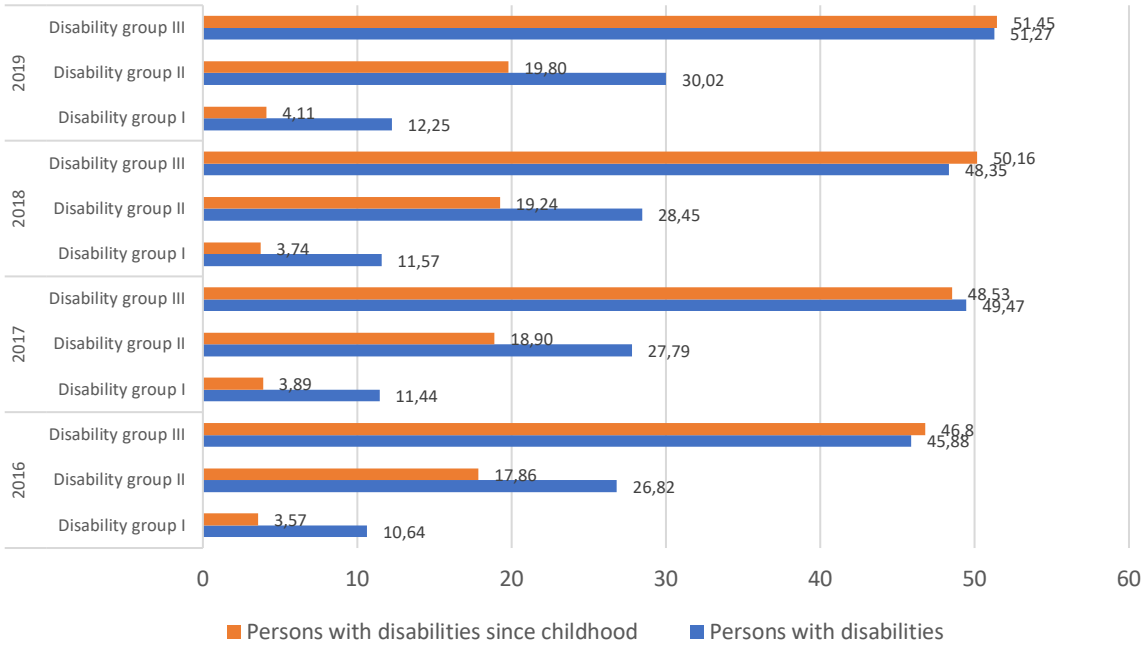
Figure 5.5 -Employed persons with disabilities since childhood (18 to retirement age) in the number of beneficiaries of disability pension and state social security benefit by severity of disability 2016-2019*



Source: SSIA, data on the beginning of the year
**Excluding persons with disabilities beneficiaries of old age pension.*

In 2019, the highest employment rate was for persons with a Group III Disability: 51.45 percent – an increase of 5.4 percentage points since 2016 (Figure 5.6). The percentages are much lower in the case of Group II and Group I Disability: 30.0 percent and 12.25 percent, respectively.

Figure 5.6 -Employed disabled persons and persons with disabilities since childhood in the number of beneficiaries of disability pension and state social security benefit by severity of disability 2016-2019 (%)*



Source: SSIA, data at the beginning of the year.
**Excluding persons with disabilities beneficiaries of old age pension.*

Another source of data on employment of persons with disabilities is **EU SILC**. In this survey, disability is defined as "long-standing limitations in usual activities due to health problems". It is self-reported. In 2018 (as in 2017), 40.0 percent of the Latvian population reported experiencing disability (see Chapter 1). Among them and looking at the subsample of 20-64 years old, 61.1 percent reported being employed, which is lower than the rate for their non-disabled peers (80.0 percent), but much higher than EU average (52.0 percent) and EU27 average (50.8 percent).[197]

5.1.2 Unemployment

Between 2016 and 2018 the overall unemployment rate in Latvia fell from 9.6 percent in 2016 to 8.7 percent in 2017 and 7.4 percent in 2018.[198] The number of persons registered with PES at the end of the year fell from 78,357 persons in 2016 to 63,121 in 2017 and 59,588 in 2018 or by 24.0 percent. The number of persons with disabilities registered with PES as unemployed fell from 9,441 in 2016 to

[197] See: "Master tables concerning EU 2020: year 2018. Prepared for the European Disability Expertise (EDE) by Stefanos Grammenos (in collaboration with Mark Priestley). Statistics on Persons with Disabilities (2018) Employment, unemployment, activity, education (Early school leavers & Tertiary education). Source of data: EU-SILC 2018. Release 2020 version 1 Prevalence, Low work intensity, Risk of poverty (financial poverty), Material deprivation, At risk of poverty or social exclusion & Health Eurostat."
https://ec.europa.eu/eurostat/data/database. Extracted on 13-07-2020.
https://www.disability-europe.net/downloads/1046-ede-task-2-1-statistical-indicators-tables-eu-silc-2018

[198] In 2019 it fell further to 6.3 percent. Unemployment rate is calculated as percent of unemployed persons in the labor force (employed plus unemployed persons).

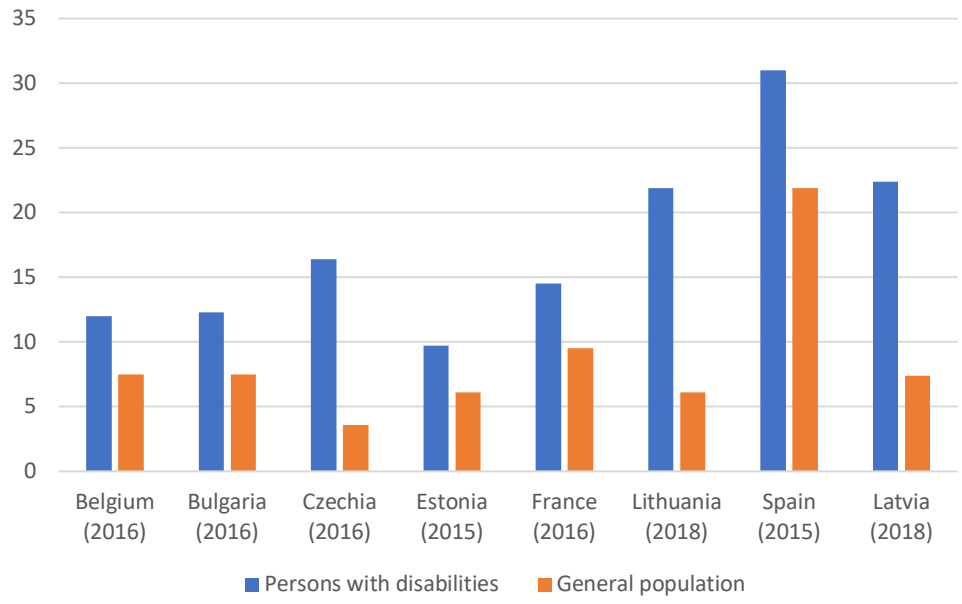
8,234 in 2017 and 8,179 in 2018 or by 13.4 percent. Reflecting the changes in the total number of registered unemployed people, the share of people with disabilities in the total population increased from 12.0 percent in 2016 to 13.7 percent in 2018.

It is difficult to determine whether the decline in the number of persons with disabilities registered with PES was due to persons with disabilities getting steady employment or whether at least in some cases people dropped out from the PES registry. It could also be that persons with disabilities found jobs with no PES assistance. More importantly, the change between 2017 and 2018 was almost negligible. It seems that PES has no data that would allow a robust monitoring of labor market participation of persons with disabilities.

The unemployment rate of persons with disabilities (calculated as percent of labor force composed of persons with disabilities, i.e. employed plus unemployed persons with disabilities), is significantly higher than the general unemployment rate. In 2016, it was 26.3 percent (compared to. 8.7 percent in general); while in 2018, it was 22.4 percent (as compared to 7.4 percent in general). However, the trend has been positive, as the unemployment rate of persons with disabilities decreased by 8.5 percent between 2016 and 2018.

Internationally comparable data on employment and unemployment rates of persons with disabilities are scarce and often old. Figure 5.7 presents some of the unemployment rate data compiled by the International Labor Organization (ILO). Data for Lithuania and Latvia are the report team provisional estimates. As illustrated by the Figure, Latvia has one of the highest unemployment rate of persons with disabilities and has the third highest gap in unemployment between general unemployment rate and unemployment rate of persons with disability (Czech Republic has the highest gap, followed by Lithuania). As discussed throughout this report, one of the contributing factors why there is low labor market participation of persons with disabilities is likely the overall tilt of disability policy, which does not prioritize interventions to keep persons experiencing disability at work.

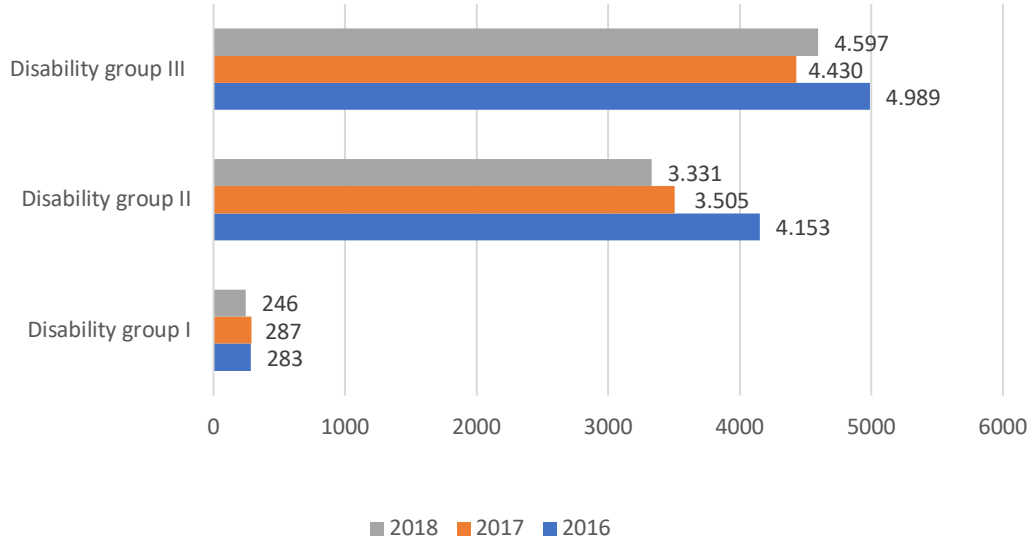
Figure 5.7 - Unemployment rate of persons with disabilities



Source: ILO and the study team.

The number of persons with Group I Disability registered with PES is small and it decreased between 2016 and 2018: from 283 to 246 persons (13.1 percent). In the case of Group II Disability, the number decreased by 19.8 percent, while in the case of Group III Disability the decline was 7.9 percent (Figure 5.7).

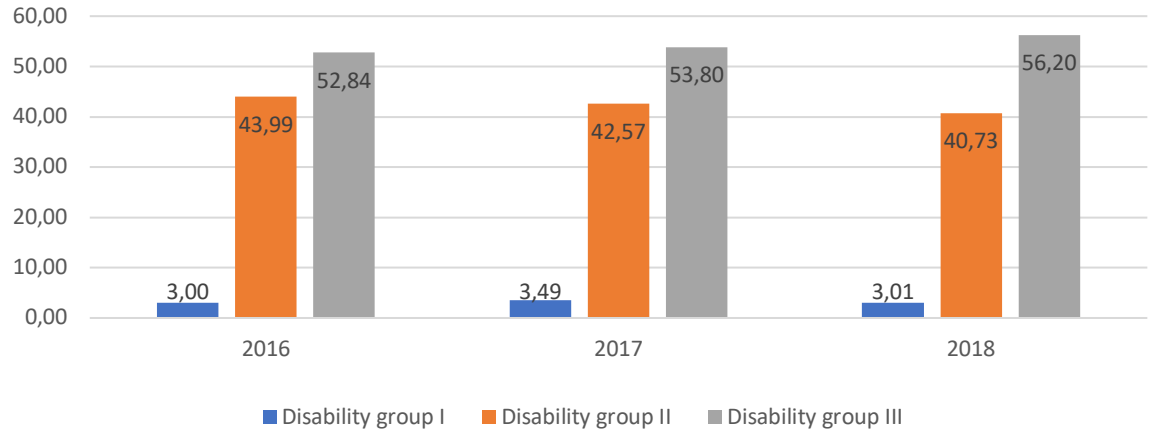
Figure 5.8 -Persons with disabilities registered as unemployed with PES, by severity of disability 2016-2018



Source: PES, data at the end of the year

Figure 5.9 presents the distribution of persons with disabilities registered with PES by severity of disability 2016-2018: in 2018, 3.0 percent had Group I disability, 41.0 percent Group II and 56.0 Group III. The share of Group I remained unchanged, the share of Group III increased and the share of Group II declined.

Figure 5.9 -Distribution of persons with disabilities registered in PES by severity of disability in %



Source: PES, data at the end of the year

In addition to administrative data, EU SILC also makes it possible to calculate unemployment rates among persons self-reporting limitations in functioning due to a long-standing health condition. According to the EUSILC 2018, the unemployment rate among persons 20-64 years of age who self-reported limitations was 13.6 percent, 55.0 percent higher than that of persons without limitations (8.3 percent). However, the rate was below that for EU (16.7 percent) and EU27 (18.6 percent). The difference is likely due to the fact that 40.0 percent of Latvians self-reported experiencing limitations, compared to 25.0 and 24.7 percent for EU and EU27, respectively.

5.2 Policies and programs to foster labor market participation of persons with disabilities[199]

i. Legal provisions

The Law on Support for Unemployed Persons and Persons Seeking Employment[200] regulates active employment measures, preventive measures to reduce unemployment, the competences of the national government and local governments in the implementation of these measures, as well as the status, rights and obligations of unemployed persons and job seekers. Following the principle of mainstreaming, legal provisions in this Law and the corresponding Cabinet Regulations[201] apply to persons with disabilities as to any other person.

The Law makes a direct reference to persons with disabilities: in the list of active employment and labor market policy measures ("measures for specified groups of persons, [...] for persons with a determined disability"); when it defines the competence of the Cabinet – "the procedures for establishing workplaces for persons with disabilities"; and when it stipulates that "*a person with a determined disability shall also be considered to be able to work…*"

Other provisions of the law include the right to acquire the status of an unemployed person or a job seeker, to participate in active employment and preventive measures to reduce unemployment, the rights and duties of the unemployed person or job seeker. All these provisions apply to persons with disabilities as to any other person.

The Law provides for the following active labor market and employment measures:

- occupational training, retraining and improving skills and qualifications;
- temporary public work;
- measures to increase competitiveness;
- job search support measures;
- measures for specified groups of persons, including persons with disabilities;
- internship, apprenticeship and workplace-based learning, which also provides an opportunity to determine vocational suitability;

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[199] Active labor market policies (ALMPs) are government programs that intervene in the labor market to help the unemployed find work. They seek to intervene between labor supply and demand by contributing either directly to matching, or to enhancing supply, reducing supply, creating demand or changing the structure of demand (for example in favor of disadvantaged groups). ALMPs include public employment services and administration, labor market training, special programs for youth when in transition from school to work, labor market programs to provide or promote employment for unemployed, and special programs for persons with disabilities.

[200] The Law on Support for Unemployed Persons and Persons Seeking Employment 2002. Riga: Saeima. Available at: https://likumi.lv/ta/id/62539-bezdarbnieku-un-darba-mekletaju-atbalsta-likums

[201] Cabinet of Ministers: "Regulation of the Cabinet of Ministers Regarding the Procedures for Organizing and Financing of Active Employment Measures and Preventative Measures for Unemployment Reduction and Principles for Selection of Implementers of Measures, 2011". SI 2011/75. Riga: https://likumi.lv/ta/id/225425-noteikumi-par-aktivo-nodarbinatibas-pasakumu-un-preventivo-bezdarba-samazinasanas-pasakumu-organizesanas-un-finansesanas-kartibu-un-pasakumu-istenotaju-izveles-principiem

- training with an employer;
- complex support measures;
- other measures within the framework of the EU Structural Funds (ESF).

As noted earlier, persons with disabilities are entitled to PES measures as any other PES beneficiary. They can also participate in measures to reduce unemployment, such as career counseling, skills improvement programs, retraining and further education programs, programs to promote regional mobility, facilitate learning of the Latvian (official language), lifelong learning programs, as well as in other measures within the framework of ESF. Detailed description of programs is provided in Annex 9 to this report.

One of the documents setting out the national employment policy is the *Guidelines for Inclusive Employment 2015-2020*[202], a framework document for the implementation of active employment measures funded by the state and also by the ESF.

Active labor market and employment policy measures (ALMP) and preventive measures to reduce unemployment are implemented by the State Employment Agency -- Latvian Public Employment Service - PES.[203]

ii. Accessing services of PES

PES performs several tasks, including registering job seekers, informing about job vacancies, organizing cooperation and information exchange between employers and unemployed persons, providing consultations on the occupational suitability, selecting appropriate occupation and vocational training, issuing licenses and supervising the work placement service providers.

To receive services, a person must apply to PES in person, by post or electronically, requesting to be granted a status of the unemployed or a job seeker. The applicants are requested to sign the Certificate Form, confirming their eligibility, and submit it together with the application. Within one working day (three weeks if more than 30 applications have been received) a PES branch employee should respond scheduling an appointment (within 10 working days from the date the application was received). A decision on the status by granting, refusing or renewing the application is made based on the submitted documents.

The PES employee:

- Checks whether the applicant meets the requirements to be granted the status of not working; seeking work, able to work and is prepared to enter into employment relationships immediately (i.e. she or he has reached the age of 15 and has not reached the age at which she or he is eligible to receive a state old-age pension or the state old-age pension has not been granted -- including before the mandatory retirement age).
- Checks whether the applicant has not been enrolled in basic education or secondary education program, does not perform commercial activity or commercial activity has been suspended, is not in prison, does not receive long-term social care or social rehabilitation services financed entirely from the state or local government budget.
- Makes a decision, signs the decision and presents it to the person who, by signing two copies, certifies that s/he has met the eligibility requirements. One copy is kept in the personal file at PES; the other copy is given to the person.

[202] Cabinet of Ministers: "Order on Guidelines for Inclusive Employment 2015-2020, 2015". Order No. 244. https://likumi.lv/ta/id/273969-par-ieklaujosas-nodarbinatibas-pamatnostadnem-2015-2020-gadam

[203] The information for disabled persons is summarized in the section "People with Disabilities" on PES website: http://www.nva.gov.lv.

- Informs the job seeker or the unemployed person about the duties, rights, and the course of future cooperation. The person is then required to sign to, certifying her or his agreement to comply with the requirements.
- Informs the unemployed person about the possibility to apply for the unemployment benefit.
- Profiles the unemployed person, either same day the status of the unemployed person is granted or during a subsequent visit. The profiling results are filed electronically in the Profiling Results Form. Based on the profiling, each person is classified into one of the following: (i) Group 1: Unemployed with high job finding opportunities; (ii) Group 2: Unemployed with average job finding opportunities, and (iii) Group 3: Unemployed with low job finding opportunities.
- The profiling and classification are done based on education, work experience, previous occupation, skills, demand for a particular occupation, the length of unemployment, and potential risks to finding a suitable job (including age, disability, insufficient education, low demand for particular skills; and insufficient mobility opportunities). The self-assessment questionnaire is also considered.
- Determines the most appropriate available active employment measures (in accordance with the *Profiling Group Measures)* as well as the intensity of the cooperation (from "as needed" to "not less than once every two months".) For some services, such as "Measures for specific groups of persons" or the "Motivation program for job search and social mentor services for the long-term unemployed with disabilities", a family or treating physician`s statement,[204] including a reference to the need for the services of a sign language interpreter or support person (or diagnosed mental disorders) should be submitted as well to PES.
- Plans activities with the objective to enable individuals to participate in the labor market as soon as possible on their own and through services provided by PES - offering suitable vacancies registered at PES and providing measures to improve the person's labor market competitiveness and assist with career planning.

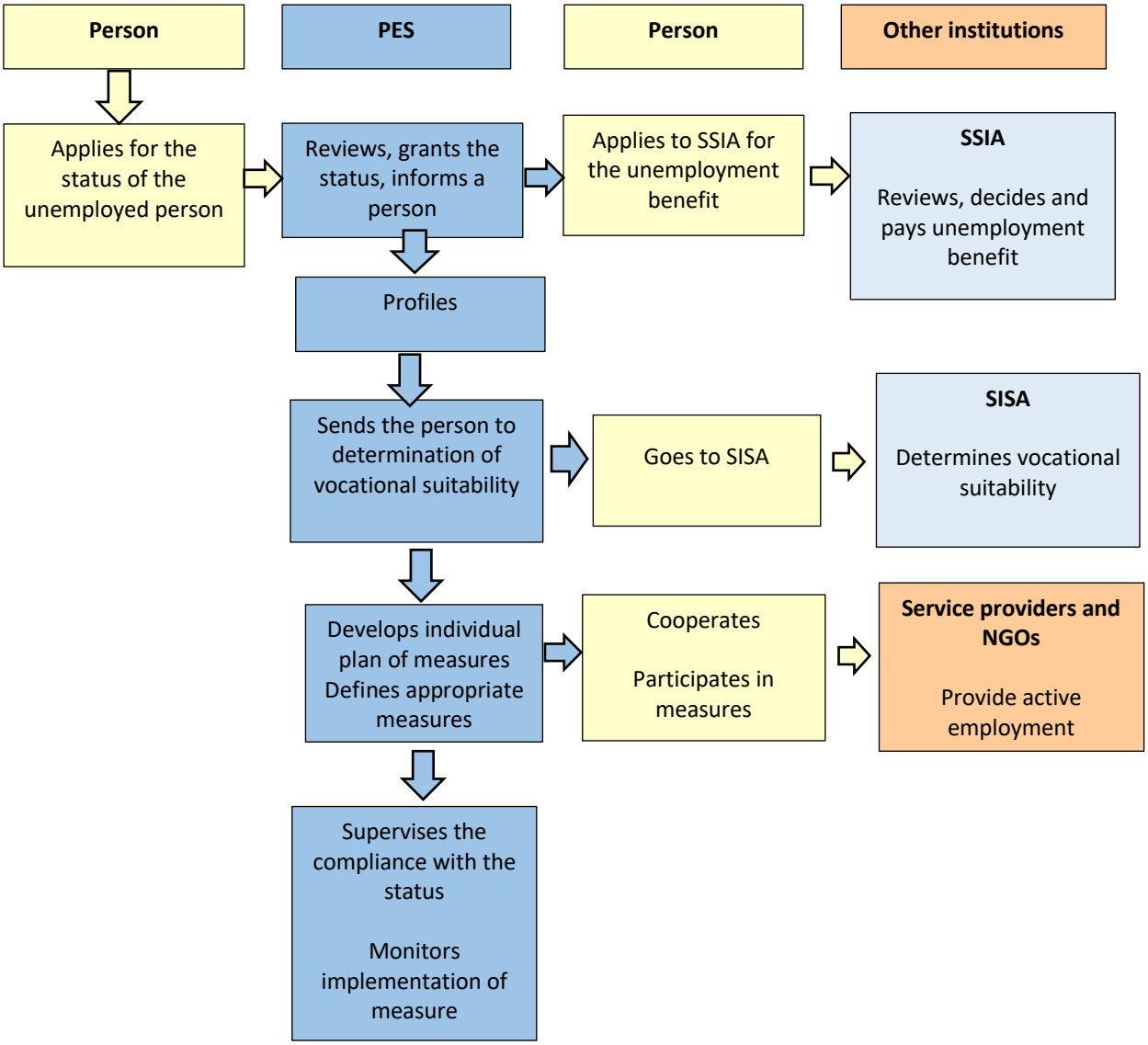
A person with disability is responsible to inform PES about impairments and health problems that are the reasons why she or he cannot perform certain tasks. This information should be corroborated by a statement from the treating physician.

This step seems unnecessary as a person could instead provide a disability certificate, or PES could acquire the certificate from SMC. The only piece of information needed are a couple of questions on disability that could be added to the application form.

A simplified description of PES business processes is provided in Figure 5.10.

[204] Form No 027/u "An Extract from the Record of an Inpatient/Outpatient Medical Card" must be submitted, in addition to the family or treating doctor statement.

Figure 5.10 -PES business processes flow



Source: Prepared by the study team.

iii. PES services for persons with disabilities

As noted, persons with disabilities are entitled to receive all services provided by PES to job seekers or the unemployed, as well as to receive the unemployment benefit (which is paid by SSIA), if PES has granted them a status of an unemployed person. One of the conditions for receiving PES services is to register with PES, which is a voluntary choice for disabled people.

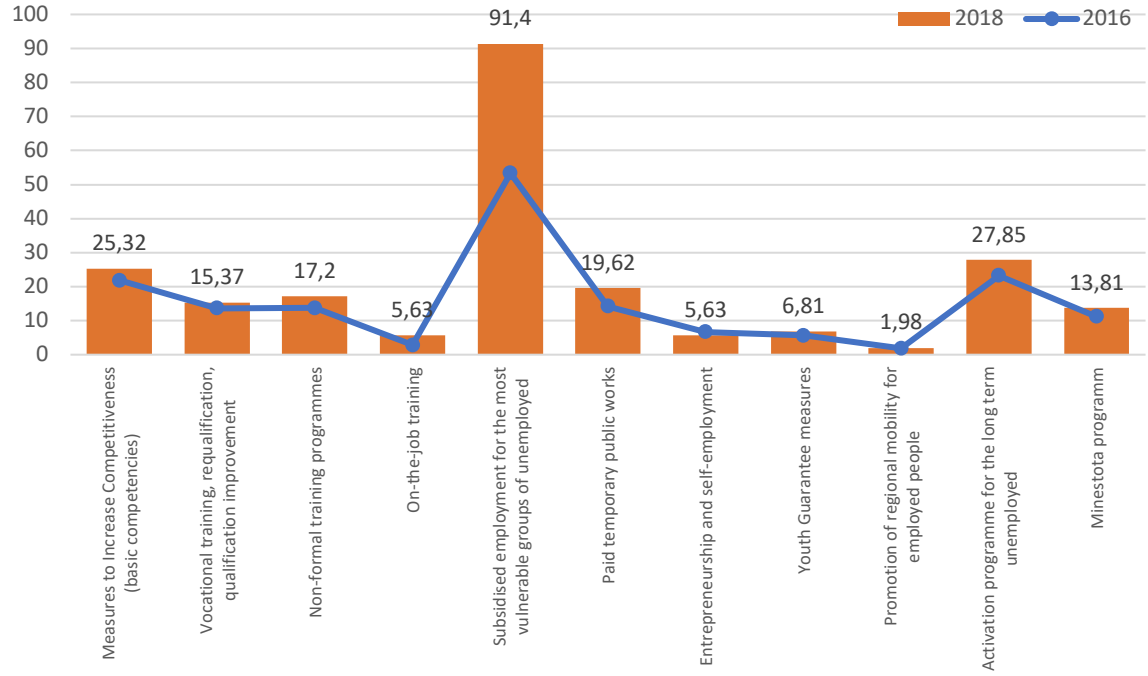
PES publishes monthly and annual data on its beneficiaries. According to PES data, more than half of persons with disabilities registered with PES are older than 50 (58.0 percent in 2016 and 63.8 percent in 2018). The share of young people with disabilities (15-24 years old) is negligible, 3.0 and 2.0 percent, respectively. This reflects the age composition of persons with disabilities, where persons 50 plus years of age dominate (see Chapter One). The proportion of long-term unemployed persons with

disabilities decreased from 51.0 percent in 2016 to 46.9 percent in 2018. There is no information about the determinants of this decrease.

Among people with disabilities registered with PES there is a significant number of support workers, cleaners, street sweepers, retail shop sellers, cooks, drivers, security guards, and care workers.[205] In 2018, there were 602 support workers with disabilities on the PES rolls, 275 retail shop sellers and 105 care workers. The data signals that older workers with disabilities, in low paid professions and often unstable jobs tend to look for a job through PES.

Figure 5.10 shows the shares of persons with disabilities in PES programs (Figure 5.11 shows the absolute number of persons with disabilities who have benefited from PES services, by the program). The shares vary, ranging from 1.98 percent in the promotion of regional mobility program to 91.4 percent in the subsidized employment for the most vulnerable groups program. It should be noted that the OECD study identified subsidized jobs as one of the measures that are "[...] less effective in boosting employment among persons with disabilities".[206]

Figure 5.11 -Persons with disabilities as beneficiaries of PES services by types of program 2016-2018 (as % in the total number of beneficiaries)

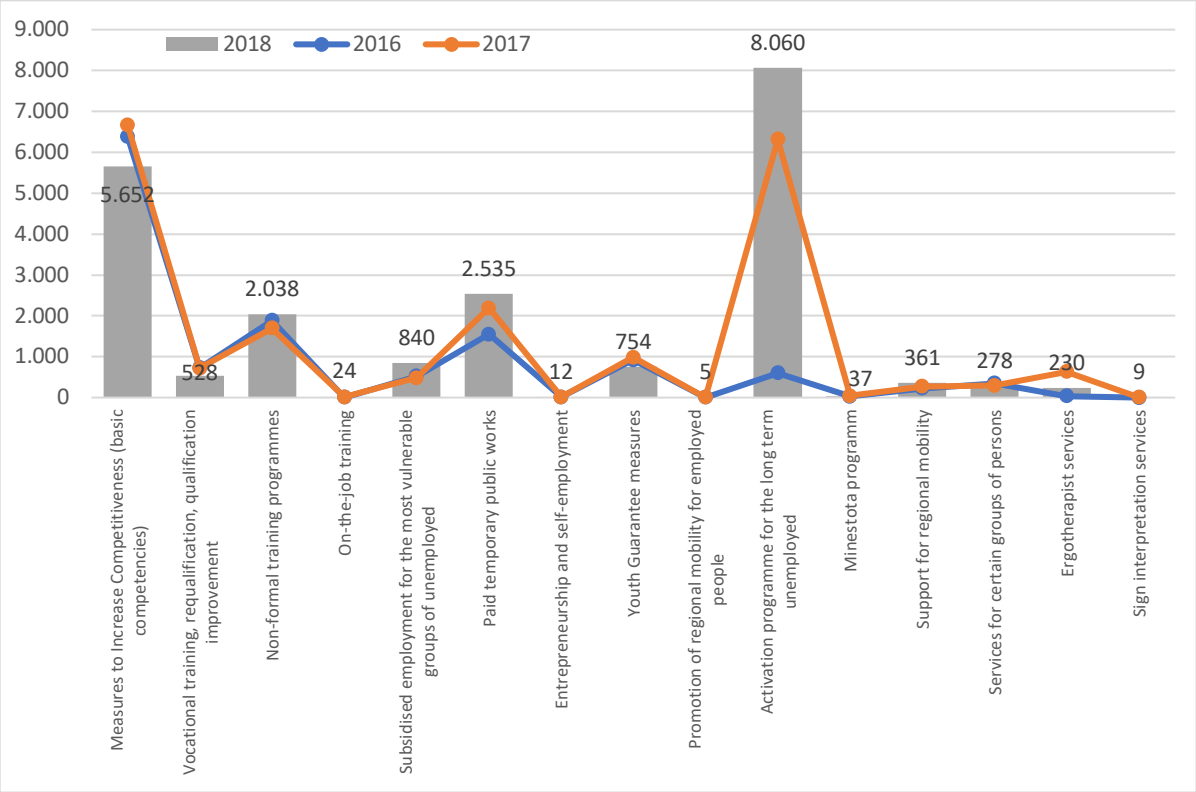


Source: PES

[205] Public Employment Service. "An Overview of the Unemployment Situation in the Country 2016". https://www.nva.gov.lv/index.php?cid=6&mid=630

[206] OECD. 2019. **Connecting People with Jobs. Evaluating Latvia's Active Labor Market Policies**. 2019. Paris: OECD publishing. p.262.

Figure 5.12 -Number of persons with disabilities who received PES services by the type of service 2016-2018



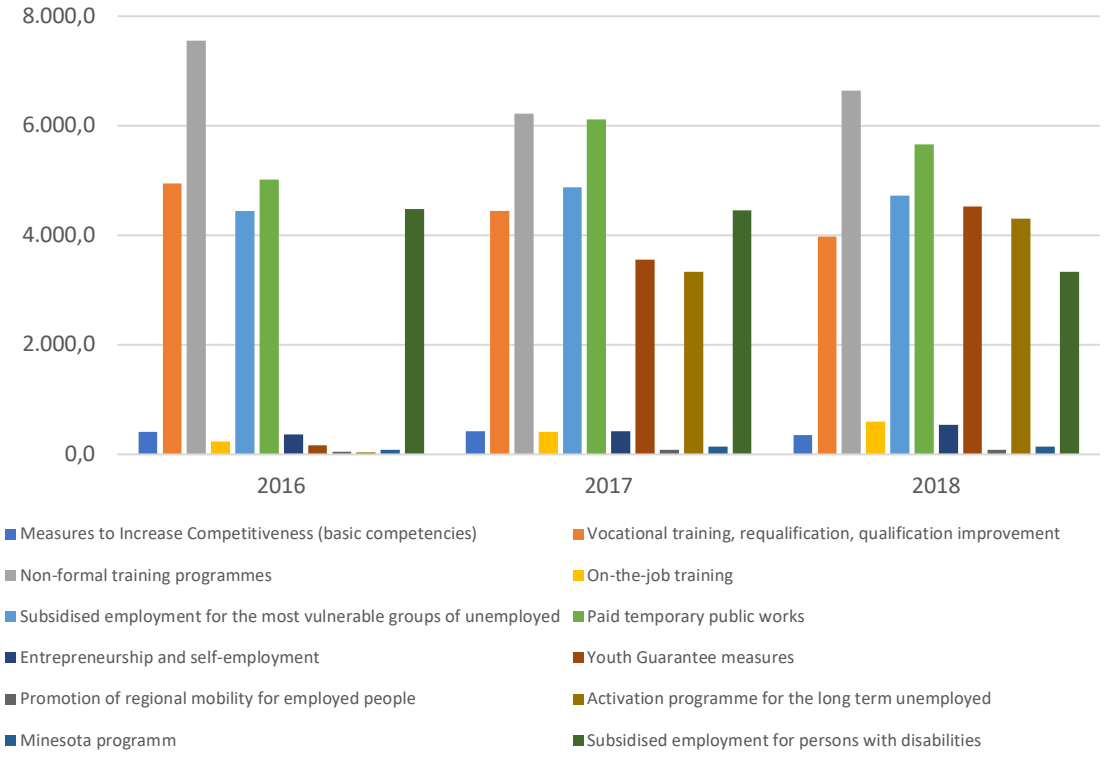
Source: PES

It is well-established empirically that for persons with disabilities, returning to employment is difficult and not many succeed.[207] Available PES data show that in 2016, 2,992 from registered unemployed people with disabilities found employment, of which 42.0 percent were provided some ALMPs services (excluding informative days). In 2018, 3,839 people with disabilities found work (of which 48.0 percent after completion of ALMPs services, excluding informative days. There is no information on the durability and type of employment. To track insertion rates of persons registered with PES and benefiting from ALMS, PES should introduce an annual indicator of the total number of persons with disabilities registered with PES over the year, the number of those benefiting from ALMPS and the number who have found the job (through PES and without the help of PES).

PES does not disaggregate spending data by disability status, except for programs targeted specifically at persons with disabilities (Figure 5.13 and Table 5.1). It should be noted that programs targeted at vulnerable groups and persons with disabilities have been funded by the European Social Fund (ESF) in 2017 and 2018.

[207] See, for example, OECD studies on work and disability.

Figure 5.13 -PES spending by key ALMP 2016-2018



Source: PES

Table 5.1 -PES spending on ALMP (000 EUR)

Measure	2016	2017	2018
Measures to Increase Competitiveness (basic competencies)	415,0	422,8	356,0
Vocational training, requalification, qualification improvement	4 947,7	4 448,8	3 979,2
Non-formal training programs	7 555,3	6 224,2	6 639,5
On-the-job training	240,1	414,5	601,2
Subsidized employment for the most vulnerable groups of unemployed	4 441,0	4 878,9	4 727,0
Paid temporary public works	5 012,4	6 115,2	5 663,4
Entrepreneurship and self-employment	368,8	423,8	543,9
Youth Guarantee measures	167,3	3 554,1	4 527,6
Promotion of regional mobility for employed people	49,6	79,6	80,4
Activation program for the long term unemployed	38,1	3 331,6	4 307,6
Minnesota 12 steps program (for alcohol, narcotic drugs or psychotropic substances addicts)	79,7	143,0	139,5
Subsidized employment for persons with disabilities	4 484,6	4 456,1	3 335,3

Source: Public Employment Service

In 2018, total PES spending on ALMPs was EUR 34.9 million (a bit over 0.1 percent of GDP) or about EUR 580 per registered unemployed/ job seeker. In 2016, the spending was EUR 27.4 million or about EUR 350 per registered unemployed/ job seeker. The increase in spending in 2017 and 2018 is due to the ESF. (As indicated in Table 5.1, some of the programs had almost negligible state funding in 2016.)

As noted, specific interventions targeted at persons with disabilities are funded within the framework of the ESF projects "Support for the long-term unemployed" and "Subsidized jobs for the unemployed". PES services are also available within the projects "Youth Guarantee", "Support to the education of the unemployed people", "Support for longer working life" and employment special budget. The programs per se are delivered by NGOs and commercial service providers (for example, "LNS Rehabilitation Centre Ltd.", and "Mācību centrs plus Ltd."). The Latvian Umbrella Body of Disability Organizations "SUSTENTO" and SIA "FIBRA" deliver motivational programs for job search and social mentor services for long-term unemployed people with disabilities. Subsidized jobs are provided by both NGOs and commercial entities. Commercial entities offer low skilled and low paid jobs such as support workers, construction workers, cleaners, and kitchen workers. NGOs offer better jobs, such as managers of interest groups, project managers, project manager assistants and assistants to persons with disabilities. PES administrative and organizational structure and cooperation with other institutions

PES is managed by a Director and two Deputy Directors. One of deputy directors is responsible for the Customer Service Management and Development Division, Information Systems Maintenance and Development Division and Statistics Division, as well as for the work of territorial 25 branches. The other is responsible for the EU Projects Department and Service Department. The PES Director oversees Financial Management Department, Accounting Department and Legal Department, as well as the Human Resources Division, Risk Management and Internal Control Division, Public Relations Division, Quality Management System Manager and the Assistant Director.

In October 2019, PES had 722 employees (about 1 employee per 80 clients). Most (93.0 percent) were women. Almost half (45.7 percent) had a status of civil servants. Almost all (98.0 percent) had higher education. The PES staff is relatively young, with more than 60.0 percent in the age group 25-54 years. More than half had work experience of up to five years.

PES territorial branches cooperate with the social service offices of local governments, in particular for the provision of services to persons who are on the rolls in both institutions, including persons with disabilities. The cooperation with other institutions is mostly limited to the exchange of data between PES, SSIA and SMC, which are necessary for the establishment of the status of the unemployed and job seeker for persons with disabilities, rather than for the provision of services. PES and SISA have concluded a cooperation agreement only in 2016 under the ESF projects "Support for the long-term unemployed" and "Determination of vocational suitability". Within this cooperation agreement, SISA provides recommendations on the appropriate work for the unemployed person, as well as on the related active employment measures according to the state of health of the unemployed person. The following groups of persons with disabilities are specified: long-term unemployed persons with disabilities or a predictable disability; long-term unemployed with mental health disorders; and long-term unemployed who have received a recommendation to have their vocational suitability determined from the health authorities. On average, per year, vocational suitability is determined for about 300 people targeted by the project.[208]

Overall, this limited cooperation reflects fragmentation of the overall disability system, including in the area of labor force participation of persons with disabilities. To benefit from PES services, a person

[208] Data from Public Employment Service.

with disabilities (or any other person) must acquire a formal status of the unemployed or job seeker. Only then, the unemployed and job seeking person with disabilities can get support.

The entire realm of programs to help people experiencing disability maintain employment (by means of multi-sectoral complex, integrated rehabilitation, workplace adjustment, and skills development) is missing.

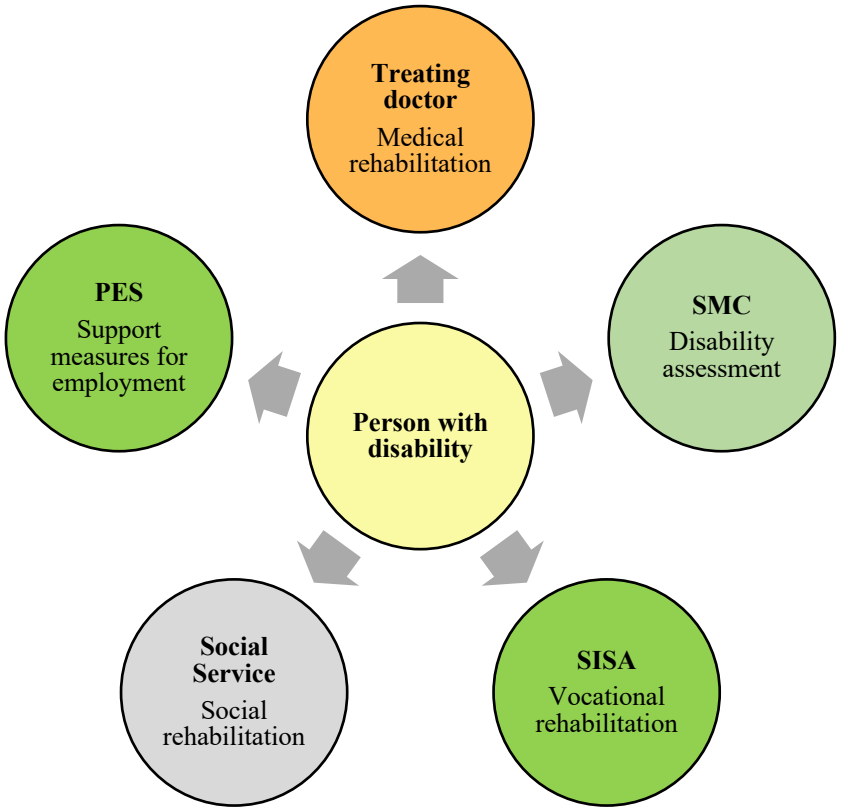
For most persons with disabilities, as empirical evidence suggests, ex-post interventions are too late. The system would need to reorient itself to ex-ante interventions, including school to work transition for young people with disabilities. Also, if an employed person with disabilities decides to leave employment after having been certified as disabled, the relevant agencies -- MoW, local social service office, PES, rehabilitation institutions, etc. -- should work together and provide harmonized assistance (should the person desire it) to help him/ her return to the labor market promptly.

iv. Other programs to promote labor market participation of persons with disabilities

Social, medical and occupational rehabilitation: In Chapter Four, we have discussed *medical, social and occupational rehabilitation*, all of which are important to support persons with disabilities maintain and improve functioning and foster their labor market participation. As noted, and illustrated in Figure 5.14, access to all rehabilitation services is a matter of individual's decision to request them, which opens questions about lack of asymmetric information. All feature separate administrative processes with program specific eligibility requirements and a decision-making process to award them. Each institution carrying out rehabilitation conducts its own assessment of the needs of a person with disabilities, prepares individual rehabilitation plan and evaluates the results. Little information, except for personal data (name and family name, date of birth, gender, ID number, etc.) is exchanged between rehabilitation programs.

Rehabilitation is not viewed as part of the continuum of services to optimize the functioning of persons with disabilities and maximize the performance of activities and participation. Instead, it is delivered as a set of separate programs provided to persons who request them and manage to meet eligibility requirements. In Latvia, a comprehensive, multidisciplinary assessment of needs of persons with disabilities matched with the service provision plan is lacking, contributing to institutional turfs, fragmentation, overlaps, inefficiencies and suboptimal results. Program evaluation and impact assessments are lacking, and it is hard to say anything about the impact of rehabilitation. In addition, rehabilitation services are not funded well, especially medical rehabilitation, resulting in long waiting lists.

Figure 5.14 -Persons with disabilities, PES, rehabilitation services and disability assessment



Source: Authors.

To conclude, rehabilitation should play a critical role on the pathway to maximize activities and participation of persons with disabilities, including in the labor market. Yet, the way in which rehabilitation services are organized and delivered in Latvia, makes it difficult to connect them to labor market outcomes for persons with disabilities.

Social enterprises: Social enterprises are regulated by *The Social Enterprise Law*[209] that entered into force in April 2018 and associated Cabinet Regulation.[210] The purpose of this Law is to improve the quality of life and to promote employment for groups at risk of social exclusion, through creation of an economic environment supportive to social enterprises. The Law creates the legal framework by providing both the criteria for obtaining the status of a social enterprise and the rules for state support for this type of entrepreneurship.

A social enterprise as defined in the Law is a limited liability company which has been granted the status of a social enterprise in accordance with the procedures laid out in the Law and which conducts an economic activity creating a positive social impact (e.g., provision of social services, formation of

[209] See: The Social Enterprise Law. https://likumi.lv/ta/en/en/id/294484-social-enterprise-law.
[210] Cabinet regulations: Regulation of the Cabinet of Ministers No.101 of 20 February, 2018 "Regulations on the Commission for Social Enterprises", and Regulation of the Cabinet of Ministers No. 173 of 27 March, 2018 "Regulations on the groups of persons at the risk of social exclusion and the procedures for granting the status, registration and supervision of a social enterprise".

an inclusive civil society, promotion of education, support for science, protection and preservation of the environment, animal protection, or ensuring of cultural diversity).

Social enterprises target, *inter alia*, employment of persons with disabilities and persons with mental health disorders. In November 2019, the Register of Social Enterprises[211] comprised 80 companies of which 14 indicated disabled persons as the first target group.[212] Two of these companies had, however, "inactive" status. Main business activities identified by the companies are manufacturing of corrugated paper and paperboard; manufacturing of paper and paperboard containers; manufacturing of electrical household appliances; manufacturing of kitchen furniture; ancillary works of art; funeral and related activities, operation of information call centers, social care of elderly and disabled persons without accommodation and elsewhere classified social care services; as well as restaurant and mobile catering services, other entertainment and recreational activities. Only one company indicated a specific objective of employing at least 50.0 percent of people with disabilities of all employees.

Social enterprises are new in Latvia and it is early to declare them a success of a mixed results programs. MOW should monitor carefully their performance, in particular concerning employment of persons with disabilities. Periodic inspections and audits and beneficiary surveys should be conducted regularly.

Employment quotas: In recent years discussions have resumed in Latvia on the introduction of employment quotas for people with disabilities in the private and public sector. Historically, the 1992 *Law on the Medical and Social Protection of Disabled Persons*[213] included the introduction of a quota system; but it was repealed in the 1996 amendments.[214]

At its simplest, quota legislation requires private and/or public sector employers, who employ a certain minimum number of workers, to ensure that a given proportion of employees consists of persons with disabilities. The quota system was introduced for the first time after the WWI (at about 1920) in Germany, Austria, France, Poland and Italy to help employ disabled war veterans.

The 2019 International Labor Organization (ILO) review of the quota system for employment of persons with disabilities shows that 103 countries had some form of quotas.[215] The Review (Volume 1) found that:[216]

- 33 of 103 countries (32.0 percent) have quotas backed by levies or fines; 64 (62.0 percent) have binding quotas (though it is unclear from the available information whether or how these are

[211] Register of Social Enterprises. Available at: http://lm.gov.lv/lv/es-finansejums/lm-istenotie-projekti/aktualie-projekti/esf-projekts-atbalsts-socialajai-uznemejdarbibai/socialo-uznemumu-registrs

[212] An example of the social enterprise statement: "The purpose of society as a social enterprise is to provide a society (population) with responsible, high-quality, professional and accessible funeral services together with a sensitive attitude and a modern approach, taking into account the socio-economic situation in the country and the principles of socially responsible entrepreneurship with a view to promoting the quality of life and developing burial services in general, by promoting the employment of population groups at risk of social exclusion leading to a favourable contribution between society and the working environment of funeral undertakers, as well as the social impact of continuous investing of profits in implementation of mentioned social objectives."

[213] The Law on the Medical and Social Protection of Disabled Persons 1992. https://likumi.lv/ta/id/66352-par-invalidu-medicinisko-un-socialo-aizsardzibu

[214] Amendments to Law on the Medical and Social Protection of Disabled Persons 1996. SI 1996/100. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/39661-grozijumi-likuma-par-invalidu-medicinisko-un-socialo-aizsardzibu-

[215] ILO. 2019. *Promoting Employment Opportunities for People with Disabilities Quota Schemes*. Volumes 1 and 2. Geneva. https://www.ilo.org/global/topics/disability-and-work/WCMS_735531/lang--en/index.htm, and https://www.ilo.org/wcmsp5/groups/public/---ed_emp/---ifp_skills/documents/publication/wcms_735532.pdf

[216] Ibid. Volume 1. Pp. 1-4.

enforced); and 6 (6.0 percent) have quotas introduced by government decisions or decrees, rather than laws, so may not be binding.

- The quota schemes vary considerably in terms of employers covered and the level of the quota obligation. They also vary in terms of who stands to benefit from the quota provisions. Enforcement methods differ too, as do the measures in place to compensate employers who fulfill the quota obligations and sanction those who do not comply.
- Out of 100 countries for which information was available, in 70, the quota schemes applied to employers in both the public and private sectors; in 24 countries to public sector employers only and in 6 to private sector employers only. In 53 countries the quota applied to employers above a certain size of workforce, with the smallest employers exempt. In 5 countries, the quota applied to all employers.
- The lowest threshold was generally 20 employees, with employers with a workforce greater than this subjected to the quota obligation. A few schemes set the threshold lower than this, while in some cases the threshold was far higher – 100 employees in several cases, and 1000 in one case. In some cases, certain sectors and types of jobs are exempt from the quota obligation.
- There is considerable variation between countries in the level of obligation posed, with the specified quota rates ranging between 1 and 10 per cent. One in five of the schemes set the quota requirements at between 1 and 2 percent; just under two thirds (62.0 percent) set the obligation at between 2 and 5 percent; 8.0 required employers to fulfill a quota of between 6 and 7 percent.
- In order to benefit from the quota provisions, people with disabilities are generally required to register as disabled or be certified following an assessment.

Interestingly, while 103 countries have some kind of quota requirements, as the ILO Review found, information on how effective they are in increasing employment of persons with disabilities is sparse. Anecdotal evidence from many countries suggests that employers are not keen on quotas and often choose to pay fines rather than to employ persons with disabilities. In some cases, the firms retain workers who have become disabled and count them towards the quota. Some firms hire persons with disabilities "notionally", they receive the wage but have no obligation to turn to work, which defies the purpose of the quotas. One of the rare examples of empirical analysis of the quota system performance was done for Spain.[217] A statistical analysis of data for 4,000 firms found that the impact of the quota system was low.

The quota system in Latvia will likely have a very low, if any, impact on employment of persons with disabilities. In 2017, there were in Latvia 181,424 economically active companies. Most (90.8 percent) were micro-enterprises (0-9 employees) and would likely be exempt from the quota requirement (the ILO review found that in most cases the minimum required company size is 20 workers). Five percent are small enterprises (10-49 employees). Only 0.9 percent are medium-sized, and 0.13 percent are large companies. Consequently, the quota system could likely be applied to 1-2 percent of companies if the minimum workforce size is 20 workers. (This minimum number could be increased to 50, as it is Spain).[218] Assuming that the quota system would affect 100,000 employees, a 2 percent quota will amount to 2,000 jobs for persons with disabilities at the quota introduction and likely with very few jobs in the subsequent years. Quotas in the public administration would likely have low impact as well, as Latvia is reducing the number of employees in the public sector.

[217] Malo, M. and Pagan, R. 2014. "Hiring workers with disabilities when a quota requirement exists: The relevance of firm's size". https://www.researchgate.net/publication/257021597

[218] Central Statistical Bureau. Databases. SRG030. http://data1.csb.gov.lv/pxweb/en/uzn/uzn__01_skaits/SRG030.px/table/tableViewLayout1/

Another challenge is a mismatch between the demand and supply. Both private and public sector demand highly skilled workers. In contrast, persons with disabilities looking for a job, tend to be over 50 years of age, long-term unemployed and with low skills.

Finally, enforcing the quota system, as evidenced by many countries, is a complex administrative issue, entailing significant cost.

To conclude, the quota system may not deliver expected results. Instead, as already pointed, Latvia should focus on building an integrated system of programs to support labor market participation of persons with disabilities. In any case, the discussion about the quota system should be informed by experience of other countries and an assessment of its impact on employment of persons with disabilities, including its cost-effectiveness.

Key findings and recommendations

Findings

Based on administrative data, Latvia has low labor force participation, low employment (even among Group III disability, only half is employed) and high unemployment rates of persons with disabilities. Comparatively speaking, as shown in Figure 5.7, the rate of unemployment stands out relative to other countries. Most of persons with disabilities of working age (about two thirds) do not participate in the labor market. For a rapidly aging country, this is a challenge that would need serious consideration, if not in the short-, then in the medium term.

To benefit from active labor market policies for persons with disabilities, a person with a disability must be certified as disabled and registered as an unemployed person with PES. A person can go to PES without disability assessment as well, however he or she will not benefit from those measures where disability is an eligibility criterion. About half of persons with disabilities who find employment do so without assistance from PES. Long term unemployed persons with disabilities, those nearing retirement and those with low or no qualifications tend to register with PES. Spending on active labor market programs is almost negligible and there are no programs to support persons with disabilities stay at work.

Like other disability policies, active labor market programs for persons with disabilities are set up almost in isolation from other policies aimed to optimize functioning of persons with disabilities and maximize their activities and participation. This is one of key issues with disability policies in Latvia: programs rarely talk to each other – they are not viewed as part of a range and continuum of services, rather, they are delivered as separate programs to persons who request them at their personal initiative and manage to meet eligibility requirements.

In Latvia, a comprehensive, multidisciplinary assessment of needs of persons with disabilities matched with the service provision plan is lacking, contributing to institutional turfs, fragmentation, overlaps, inefficiencies and suboptimal results. Periodic evaluation and impact assessments are lacking, and it is hard to say anything about the impact of any program, including active labor market programs.

Data on labor market participation of persons with disabilities are rather basic and do not allow for a more comprehensive analysis. For instance, there is no information about labor market status of persons who get certified as disabled for the first time: do they keep working, do they work part time, do they leave employment permanently or temporarily, would they want to continue working but in a different job with the same employer, etc. Collecting these pieces of information could be invaluable for designing and planning labor market policies targeted at persons with disabilities. Moreover, acting

early, while persons are still on a sick leave may help many keep their jobs, even after they have been certified as disabled. This would be much more effective than setting up employment quotas for persons with disabilities.

Recommendations

As noted, in 2019, OECD published a report on active labor market policies in Latvia. The report provides eight key recommendations, that are presented in Box 5.1. They are all pertinent to persons with disabilities, as well.

Box 5.1 - OECD active labor market policies recommendations

The OECD (2019) study on Latvia's active labor market policies[219] came up with the following key policy messages, which may improve the performance of active labor market policies in Latvia:

- Introduce possibilities for less severe sanctions when individuals turn down job offers but require that unemployed persons without family commitments accept job offers from anywhere in Latvia.
- Simplify the tool used to profile unemployed people, better link it to different streams of activation measures, and improve its accuracy by profiling unemployed people as soon as they register with the State Employment Agency and making better use of existing statistical information.
- Extend activation measures to those who are not (yet) unemployed and provide online services to those unemployed people who are more likely to resume work quickly.
- Revise the voucher system used to disperse training for the unemployed, by reducing the time for which individuals must wait to receive a voucher and lengthening the time for which vouchers are actually valid, in order to limit lock-in effects.
- Monitor choice and competition in the training voucher system as the number of training providers is reduced and ensure that caseworkers are able to provide special support to those disadvantaged voucher recipients who need help in exercising effective choice.
- Enhance regional mobility support for training participants, extend regional mobility support for families by arranging for additional access to credit, and link access to regional mobility support to the profiling tool rather than requiring people to have been unemployed for at least two months before becoming eligible.
- Consider differentiating the program of employment subsidies for persons with disabilities according to the degree of assessed disability or work capacity.
- Continue to invest in building and maintaining a well-functioning data infrastructure and develop mechanisms for conducting ongoing monitoring and evaluation of active labor market policies.[220]

In addition, and based on the observations presented in this chapter, the following is recommended:

Introduce multidisciplinary needs assessment and service matching. Ideally the needs assessment will be conducted (i) for persons facing a risk of disability to ensure that all available measures that could prevent and mitigate that risk are undertaken in a holistic manner; and (ii) during disability

[219] OECD (2019), *Evaluating Latvia's Active Labor Market Policies*, Connecting People with Jobs, OECD Publishing, Paris. https://doi.org/10.1787/6037200a-en
[220] Ibid. p. 16.

assessment. Adopt a principle of referrals, instead of demand-based service provision. (See also recommendations in Chapter Four.)

Make employment support for persons with disabilities part of an integrated service provision model. This model is a client-centered model, where all available measures that are aimed at optimizing functioning, and participation are undertaken early, i.e. before a person is referred to SMC for disability determination. For employed persons at risk of disability this approach to service provision will help ensure continued employment. The model includes early multidisciplinary functioning and needs assessment, case management, an integrated rehabilitation plan development and close cooperation between the person, her/his employer, medical professionals, vocational rehabilitation specialists, employment services, local social welfare office, education specialists (for young people with disabilities), and others. Latvia has all the key elements to develop such a system. The key challenges are overcoming institutional fragmentation and reorienting service provision towards a client-cantered collaboration guided by an agreed rehabilitation plan and case management.

The integrated service provision model requires an integrated information system to underpin it. This entails, for example, storing the information from individual rehabilitation plans for persons with disabilities in a single data system for further, sequential use of information. Ensure that the data system steward is MOW, so that it stores and uses data from the services planned and provided by the social service offices, SMC, PES, SSIA, SISA. Ideally, this data system will also comprise data on medical rehabilitation services, or at least have a possibility of data exchange with E-Health.

Improve public employment services for persons with disabilities, including by strengthening PES human resource capacity to effectively serve clients with disabilities. This can be accomplished by, i*nter alia* training staff to work with clients with disabilities; introducing and training job coaches who would assist with appropriate job placement of disabled people, familiarizing staff with the ICF concept of functioning, establishing multi-disciplinary teams and increasing the staff complement to include occupational rehabilitation specialists, psychologists, educational specialists, and others.

Expand public employment services for clients with disabilities, including by supporting: (i) persons with disabilities to keep their employment, by, for example, providing workplace accommodation; (ii) expanding services for school-to-work transition for young people with disabilities; (iii) employers who of persons with disabilities, by sensitizing them to the benefits of employing persons with disabilities and helping them and other employees overcome prejudice. In collaboration with the education sector increase the role of vocational training for persons with disabilities.

Increase spending on ALMPs. The expansion of services requires that more resources be invested in ALMPs.

Consider changes to the existing programs to support labor market participation of persons with disabilities and persons caring for them. For example, consider differentiating the level and duration of wage subsidy by severity of disability and according to the individual rehabilitation plan. Consider introducing a gradual scaling down of wage subsidy. For the caregivers of children and adults of disabilities, consider introducing a possibility of flexible working hours, adding more days of paid leave and introducing a possibility of unpaid leave in certain situations.

Continue regular monitoring and impact assessment. Although studies such as the OECD study are extremely useful, in order to better monitor the participation of persons with disabilities in active labor market programs using existing data and frequently assessing program delivery is also required. It is also a good practice to pilot programs before rolling them out. Based on an in-depth assessment, ineffective programs should be adjusted or discontinued to improve program performance.

6. AN OVERVIEW OF KEY RECOMMENDATIONS

Throughout the previous chapters, we have stated findings and suggested actions to further develop and improve the disability system, policies and programs. In this chapter, for easy reference, we list key recommendations by chapters.

Photo credit: https://www.shutterstock.com/.

6.1 Disability at a Glance

Conduct an in-depth study to determine the factors that are driving disability rates up and to what extent. It is important to identify these factors because of the projected aging and shrinking of the population during the next several decades: the UN projects that the Latvia population will decline to 1.48 million by 2050 and that the median age will increase due to low fertility (now down to 1.34) and growing life expectancy. These factors will inevitably result in a growing share of elderly in the total population. Given that aging is associated with increased rates of disability, disability rates are expected to increase as well. This is significant since Latvia is among those countries in which disability status and support provided through the disability system is also provided to elderly people.

Plan for future in which a significant fraction of the population will be elderly, many of whom will be experiencing disability. It is important to focus on disease and injury prevention, healthy living and aging, as well as on policies to increase social participation, especially that increase employment for those who are able and willing to stay in the labor market. Such policies are key to mitigating the social and economic impact of an aging population increasingly experiencing disability.

6.2 Disability Policy and System: Legal Framework

Develop a glossary of terms pertaining to persons with disabilities to guide policymakers and practitioners.

6.3 Disability Assessment System

As stipulated by pertinent legislation, disability assessment should focus on activity limitations and participation restrictions rather than on medical conditions and impairments alone. This implies further finetuning the disability assessment procedures, including a face-to-face interview, functioning assessment scoring and the use of an evidence-based algorithm for determining the extent of disability.

Regulations pertaining to disability assessment, including criteria of assessment and related health and social services, should be reviewed and revised in order to achieve comprehensiveness and conceptual consistency. This requires a whole government approach and close collaboration between MOW, MOH, and other ministries responsible for policy areas pertinent to disability.

The government should consider abolishing predictable disability and replacing it with coordinated efforts to optimize functioning and participation of working age adults in the labor market. This will require the involvement of social services, medical and occupational rehabilitation professionals, employment services, employers, and others in order to objectively assess work capacity with a view of maximizing labor force participation. Services, assistive and technical aids, and work-place accommodation should be provided during this period. For consistency, the same tools for disability assessment should be used to assess functioning. It is essential that there be a close collaboration and coordination between SMC, MOW and MOH. All information from conducted assessments and services provided should be available to SMC, in case a person is assessed for disability.

Disability certification should not be a precondition for persons to receive publicly financed services such as vocational rehabilitation, technical aids, workplace adjustment, etc. In some cases, particularly for employed persons, a range of services may be needed to prevent or mitigate disability and help the person stay in employment. This, however, does not imply that persons assessed as disabled should not get needed services. Quite the opposite. Furthermore, disability certification is needed for persons with disabilities to access benefits in cash and other benefits specifically targeted at persons with disabilities.

Standardized and validated tested assessment tools should be used to assess limitations in activities and restrictions in participation.

The same criteria and valid tools for assessing disability should be used to assess work capacity whether or not the health condition is associated with occupational health or general health.

Medical reports should be standardized and requested information should match disability assessment criteria, i.e. information should enable the criteria to be applied.

For first-time disability assessments, the functioning questionnaire should be filed out by a trained SMC professional in a face-to-face clinical interview. This interview should be conducted for predictable disability as well (on the assumption that predictable disability is strengthened as recommended above). For reassessments, the medical report and self-assessment may continue, but with monitoring to assess effectiveness. The possible benefit of including instead a face to face interview should be kept available.

The SMC should be strengthened by (i) developing human resources and (ii) overhauling the existing DIS. Staff should be trained in ICF, with regular refresher courses. Paper processing and paper records should be phased out in favor of electronic reporting. Along with MOW, SMC should become one of the major stewards of data to analyze Latvia's disability situation and to identify trends for better, evidence-based disability policy development.

MOW should consider adding a needs assessment to disability assessment. Persons with disabilities could be advised which services are available to them and where to obtain them and the referral could be automatic. This would require changes in the staff complement that assesses disability and it could be planned in the medium term.

6.4 Support to Persons with Disabilities

Overall recommendations

Conduct a thorough review of all disability support measures irrespective of who provides them. The review should include program objectives, implementation arrangements, beneficiaries, spending, and performance in terms of achieving the objective. It should serve to identify gaps in support measures and identify options for a more cost-effective support to persons with disabilities. Our brief review shows that some programs serve a small number of beneficiaries at high average cost. The review should indicate whether it is cost-effective to keep, to discontinue or transform these measures.

Another issue where the review would be helpful is to identify programs with similar objectives -- e.g. material or monetary support to persons with disabilities -- and consider consolidating them into one program. It goes without saying that the new benefit should be at least equal to the sum of benefits consolidated into it. The review, which should be multisectoral and multi-stakeholder, should provide empirical evidence in order to create a disability support measures development roadmap and an action plan.

Introduce comprehensive needs assessment. Disability is a journey during which there are many opportunities to act to prevent or reduce its impact by optimizing functioning and enhancing participation. To intervene in a timely and appropriate manner, a comprehensive needs assessment is required.

One can broadly identify two phases in a disability journey: (i) pre-disability certification; and (ii) post disability certification. The first would normally start with a post-acute phase of an illness, trauma or injury. At this point there is an opportunity to provide medical rehabilitation, technical aids, vocational rehabilitation, and for individuals who are employed to discuss with the employer options to accommodate the workplace or provide different job placement. The needs assessment could for employed individual be conducted when a person comes to SMC for an extension of a sick leave. The objective of this phase is to undertake all available actions to facilitate recovery and optimize functioning, including support for continued employment.

Phase two would comprise measures to support a person after s/he has been certified as disabled. These may include a continuation of medical rehabilitation, support services, or social insurance benefits. The needs assessment should be an integral part of the disability certification process. Both assessments should be multisectoral, with participation of relevant experts and include not only the assessment of needs, but also the matching with available services and a referral to them.

Strengthen social care and rehabilitation services. Medical rehabilitation, vocational rehabilitation and social care services are all in need of significant development and strengthening, as is the provision

of technical and assistive aids. A concerted effort is needed to develop community-based social care services. Latvia needs to deinstitutionalize its care services. The process of deinstitutionalization is not simple, and it may take time to complete, but it can be achieved, with a good plan, persistence and adequate resources to develop alternative, community-based services.

Focus disability policy, institutions and support measures on optimizing functioning, and enhancing participation to improve well-being. Latvia has all the elements for effective support to persons with disabilities, although some of these elements are better developed than others. Reorienting the system towards a continuum of support, from the inception of a health condition that may result in disability, through to disability certification and support onwards would not be an insurmountable task, although it may take some time to be planned and implemented.

Improve data system: Information on individuals at risk of or experiencing disability should be available to relevant institutions implementing disability policy and programs, as well as to persons themselves. It is particularly important that information on assessments and services provided and received be recorded for better monitoring and planning. Good data is always important to ensure that persons with disabilities benefit from all support measures available to them.

Introduce periodic impact assessments and evaluations. All programs and institutions implementing them should be comprehensively reviewed periodically. It is advisable that piloting be done prior to new programs being rolled out.

Topic specific recommendations

Social care services:

- Incentivizes the implementation of the national policy for the development of community- based social care services, i.e. services alternative to institutionalization.
- Institute a principle of non-institutionalization at national and local level, to complement de-institutionalization. A strategic plan is required that would combine community-based services development, mandate no new placement into residential care, plan increased discharge from institutional care to community-based options, and create a timeline for these actions. Deinstitutionalization is a long-term process that needs to be carefully planned and executed, keeping in mind the interests of the employees and the residents.
- Increase the state financial support for local authorities to provide alternative care services.
- Make changes to the *Law on Social Security and the Law on Social Services and Social Assistance* in order to establish a minimum package of social care services that can be received free of charge; and oblige local governments to fully pay for long-term social care services in institutions.

Provision of technical aids:

- Conduct an in-depth review and audit of technical aids services, including beneficiary feedback.
- Strengthen the quality of provided services, including by significantly improving human resources.
- Strengthen the Government's role in the provision of technical aids by clearly defining policy development, implementation and reporting and monitoring responsibilities of MOW and MOH.
- Secure adequate quality of services and the provision of technical aid devices -- such as orthoses and prostheses, individually produced technical aids, respiratory technical aids, and others that require customization and close monitoring by medical and rehabilitation professionals. These services, moreover, should be integrated into the medical rehabilitation process and, thus transferred to the MOH responsibility and financing. Services could be provided in multi-profile hospitals of regional importance and medical rehabilitation institutions.

- The provision of other technical aids, such as personal care and protection and some mobility aids, e.g. industrial technical aids, could remain under MOW responsibility with the Vaivari TAC as an implementation agency under MOW.
- Move to the principle of reimbursement with contractors, whereby provided aid expenditure is reimbursed based on detailed information about beneficiaries, details about the technical aid that was provided, the cost and the information on the provider. This would also enable monitoring of the provided services.
- Improve record keeping and reporting with precise information on each beneficiary, technical aids provided and their cost. Compile information on demand for technical aids from people on the waiting list. Use this information to plan service provision and budget.
- Review, streamline and tighten procurement requirements.
- Plan the budget based on evidence about the demand.
- Increase the range of technical aid that are provided under public funding.
- Consider introducing co-pay with exemptions and depending on the income of the beneficiary.
- Increase human resource capacity of the Vaivari TAC staff to increase the quality of services it provides.
- Increase collaboration between the Vaivari TAC and social service offices of local governments in order to ensure timely and high-quality service appropriate to person`s individual needs.

Medical rehabilitation:

- Increase the importance of medical rehabilitation in the overall continuum of the health care provision.
- Expand and strengthen medical rehabilitation services, in terms of special coverage, menu of services, human resources and funding.
- Define content and outcomes of medical rehabilitation services (i.e. set standards).
- Synchronise the content and outcomes of services along the continuum of all rehabilitation services, from medical to social system to occupational. Latvia should build an integrated rehabilitation provision system with clear the objective of optimizing functioning and enhancing the participation of persons experiencing disability.
- Introduce common standards of assessment of functioning and goal setting in rehabilitation.
- Provide simple roadmaps of pathways of services for persons with disabilities for primary care physicians and other professionals providing services for persons with disabilities.
- Introduce systemic and comprehensive data collection system to enable analyses of outcomes in order to learn what works and what can be done better to reduce limitations in functioning and to assess the demand for these services.
- Rehabilitation services should be prioritized and organized in a way that promotes staying at or early return to work for persons in working age.
- Develop specific rehabilitation programmes for persons with health conditions that may adversely affect their work capacity.
- Improve awareness of patients and professionals on the importance and available rehabilitation services in Latvia.

6.5 Labor Market and Persons with Disabilities

Introduce multidisciplinary needs assessment and service matching. Ideally the needs assessment will be conducted (i) for persons facing a risk of disability to ensure that all available measures that could prevent and mitigate that risk are undertaken in a holistic manner; and (ii) during disability assessment. Adopt a principle of referrals, instead of demand-based service provision. (See also recommendations in Chapter Four.)

Make employment support for persons with disabilities part of an integrated service provision model. This model is a client-centered model, where all available measures that are aimed at optimizing functioning, and participation are undertaken early, i.e. before a person is referred to SMC for disability determination. For employed persons at risk of disability this approach to service provision will help ensure continued employment. The model includes early multidisciplinary functioning and needs assessment, case management, an integrated rehabilitation plan development and close cooperation between the person, her/his employer, medical professionals, vocational rehabilitation specialists, employment services, local social welfare office, education specialists (for young people with disabilities), and others. Latvia has all the key elements to develop such a system. The key challenges are overcoming institutional fragmentation and reorienting service provision towards a client-cantered collaboration guided by an agreed rehabilitation plan and case management.

The integrated service provision model requires an integrated information system to underpin it. This entails, for example, storing the information from individual rehabilitation plans for persons with disabilities in a single data system for further, sequential use of information. Ensure that the data system steward is MOW, so that it stores and uses data from the services planned and provided by the social service offices, SMC, SSIA, PES, SISA. Ideally, this system will comprise data on medical rehabilitation and other services provided outside the purview of MOW, or at least, there should be an exchange of information between the systems (e.g. E-Health).

Improve public employment services for persons with disabilities, including by strengthening PES human resource capacity to effectively serve clients with disabilities. This can be accomplished by, i*nter alia* training staff to work with clients with disabilities; introducing and training job coaches who would assist with appropriate job placement of disabled people, familiarizing staff with the ICF concept of functioning, establishing stablishing multi-disciplinary teams, and increasing the staff complement to include occupational rehabilitation specialists, psychologists, educational specialists, and others.

Expand public employment services for clients with disabilities, including by supporting: (i) persons with disabilities to keep their employment, by, for example, providing workplace accommodation; (ii) expanding services for school-to-work transition for young people with disabilities; (iii) employers who of persons with disabilities, by sensitizing them to the benefits of employing persons with disabilities and helping them and other employees overcome prejudice. In collaboration with the education sector increase the role of vocational training for persons with disabilities.

Increase spending on ALMPs. The expansion of services requires that more resources be invested in ALMPs.

Consider changes to the existing programs to support labor market participation of persons with disabilities and persons caring for them. For example, consider differentiating the level and duration of wage subsidy by severity of disability and according to the individual rehabilitation plan. Consider introducing a gradual scaling down of wage subsidy. For the caregivers of children and adults of disabilities, consider introducing a possibility of flexible working hours, adding more days of paid leave and introducing a possibility of unpaid leave in certain situations.

Continue regular monitoring and impact assessment. Although studies such as the OECD study are extremely useful, in order to better monitor the participation of persons with disabilities in active labor market programs using existing data and frequently assessing program delivery is also required. It is also a good practice to pilot programs before rolling them out. Based on an in-depth assessment, ineffective programs should be adjusted or discontinued to improve program performance.

ANNEX 1: Understanding Disability and Disability Assessment[221]

What is Disability Assessment?

Disability assessment is a gate through which anyone who claims any publicly or privately provided disability related benefit, service or product must pass. Every country has some form of disability assessment, some government authorized agency or agent charged with assessing whether a person is disabled or not, and to which degree. Most commonly and most visibly disability assessment is linked to social security benefits. But it also applies to eligibility for other social policy benefit: to access these benefits—from rehabilitation services, to care services, to assistive devices, to disability social pension, to social assistance in cash and in kind—people must be officially declared to have a disability.

Disability assessment affects labor supply, government spending and individual welfare. Through the power vested in them, disability assessors make decisions that affect tens of millions of working age adults (on average 6 percent of working age population in OECD countries) and influence the allocation of national resources that often surpass 1 percent of GDP in any given year (on average 1.8-1.9 percent of GDP in the OECD countries). It is estimated that aging of the population and increase in retirement age (in many countries the working age has been extended to well over 65 years of age) are bound to drive these percentages up.

Disability assessment and determination

Disability assessment is an authoritative determination about the kind and extent of disability a person has, as part of a larger administrative process usually called **disability evaluation** or **disability determination**. Disability assessment is part of a process that determines the eligibility of an applicant for some social benefit, service or protection that comprises a country' **disability policy**. These programs include social security and disability pensions; health and rehabilitation services; general social benefits such as income support; and employment-related benefits, such as unemployment benefits and workers' compensation. The **work capacity** or **work ability** assessment is the most prominent application of disability assessment, since being able to work is key to economic self-sufficiency and social standing.

Historically, disability assessment, and especially work capacity assessment, has also been closely linked to medicine, for the source of criteria of assessment, and the medical profession for assessors and adjudicators of eligibility. Medical criteria—it is commonly believed—are objective and clear and medical professionals are socially respectable and reliable. Taken together, this meant that the medical professional made a good 'gatekeeper' to public benefits. But essential to understanding the challenges of disability assessment is the controversy over the concept of 'disability' itself.

What is disability?

Since roughly the 1970s on, it was common to speak about two 'models' of disability: The Medical Model of Disability and the Social Model of Disability. The **Medical Model of Disability** purportedly claimed that disability was essentially a medical problem located in an individual's body that required a medical or rehabilitative response. This was contrasted to the **Social Model of Disability** that denied that disability was fundamentally a matter of the condition of a person's body but was rather a social disadvantage experienced by an individual, a disadvantage created entirely by social, cultural and economic conditions and beliefs. In the last two decades or so these debates have resolved in favor of

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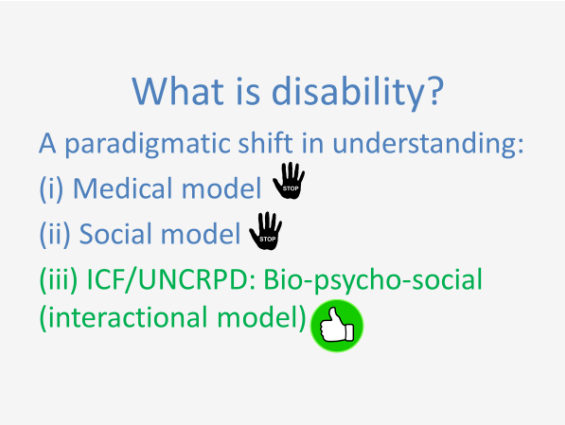
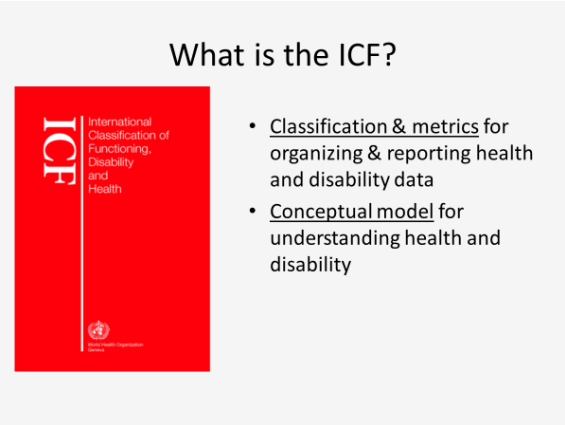
[221] From Bickenbach B, Posarac A, Cieza A, Kostanjsek N (June 2015). ***Assessing Disability in Working Age Population - A Paradigm Shift: from Impairment and Functional Limitation to the Disability Approach***. Report No: ACS14124, World Bank, Washington, D.C. 2015.

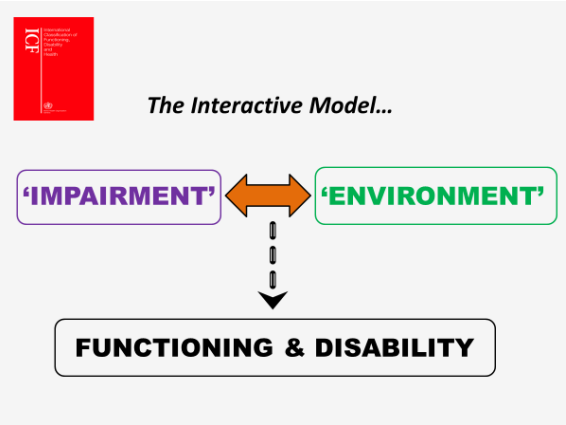
the consensus view that disability is a complex phenomenon that involves both biomedical features of a person's body or mind and the impact of the overall, physical and social, environmental context in which the person carries out his or her life.

This **interactional view of disability** is the dominant one today and the most common-sense one: disability clearly is not solely about how a person's body functions, since two people can have exactly the same impairment while one experiences a severe disability and the other little or no disability because they live in very different contexts that make very different demands on them. On the other hand, disability is not just about these environmentally or socially created disadvantages, because the body and how it functions makes a difference as well. **This interactional (or bio-psycho-social approach to disability) view of disability is at the heart of the World Health Organization's International Classification of Functioning, Disability and Health (ICF), formally endorsed by the World Health Assembly in 2001 and embraced in 2008 by the United Convention on the Rights of Persons with Disabilities (UNCRPD).**

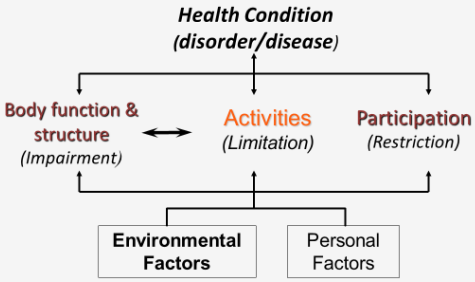
The graphic presentation below illustrates this new understanding of disability and its implications for disability assessment.







ICF 'BIOPSYCHOSOCIAL' model



Conceptualisation of Disability
ICF vs. UN CRPD

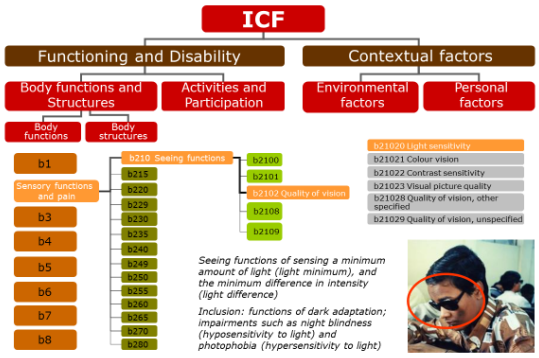
ICF **Definition** of **Disability**

"In the **context of health**. Disability is an umbrella term for **impairments, activity limitations and participation restrictions**. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors)."

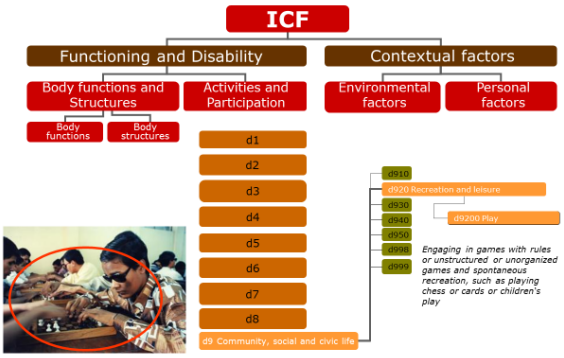
CRPD **Definition** of **Persons with Disability**

"Persons with disabilities include those who have **long-term** physical, mental, intellectual, or sensory **impairments** which in **interaction with various barriers** may hinder their full and effective participation in society on an equal basis with others."

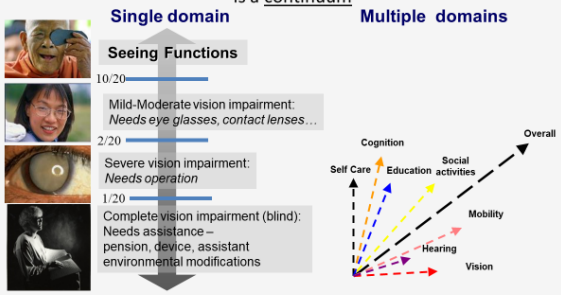
The structure and codes of the classification



The structure and codes of the classification



ICF Model:
Disability is not a dichotomy (black/white) it is a continuum



ICF Model: Disability is MULTI-DIMENSIONAL not uni-dimensional

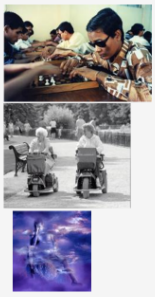
BODY
Function/ Structure
(impairment)

PERSON
Activities
(limitation)

SOCIETY
Participation
(restriction)

ICF Model: Universal not minority model
Disability can be a…

- life long experience
- late life concern
- episode in life



ICF makes the difference in health outcome measurement

Look beyond diagnosis to measure the health gains

Diagnosis according to ICD-10

B24 Unspecified human immunodeficiency virus [HIV] disease

Mr. J **BEFORE** intervention with ARVT, 2003

Functional status according to ICF

Severe/complete activity limitations & performance restriction multiple domains:
Moving around (d455.44)
Washing (d510.33)
Working (d850.44)
…

B24 Unspecified human immunodeficiency virus [HIV] disease

Almost fully functional but moderate participation restriction in Remunerative employment (d850.03)

Mr. J **AFTER** intervention with ARVT, 2004

The credibility of disability assessment

The credibility and perceived legitimacy of a country's disability assessment procedure depends on a few fundamental considerations. First, the assessments must be **valid** so there are no 'false positives' (people receiving benefits but are not disabled) or 'false negatives' (people who should be receiving benefits, but do not). Second, they must be **reliable**, in the sense that two assessors following the same rules and criteria, should come to the same assessment of the same person (often called 'inter-rater reliability'). And third, the decisions must be **transparent** and **standardized,** so that the grounds for the decision-making are publicly known and their application in particular cases independently evaluated. In short, the legitimacy of the disability assessment process depends on it being, and be seen to be, impartial, fair and based on objective evidence.

Nonetheless, depending on the social purposes and political objectives a policy or program is designed to serve, the criteria used for disability evaluation may extend beyond medical or even disability-relevant considerations to broader social considerations that may not be directly linked to the experience of disability. Historically, disability policy has been the most volatile and reactive to historical events (such as a dramatic increase in the number of returning war veterans with injuries who demand returning to their old jobs), demographic, economic and social factors. These forces have often dramatically changed the objectives of the policy, but without altering the social importance of securing accuracy in the assessment of disability.

Models of disability assessment around the world

Worldwide, strategies of disability assessment focus either on (i) health conditions and the impairments associated with them; (ii) functional limitations in basic or simple activities, understood independently of environmental or contextual differences; or (iii) disability fully understood as outcome of interactions between features intrinsic to the person (health conditions, impairments and functional limitations) and the full range of environmental factors that, possibly uniquely, characterize the overall lived-context of the individual. Each approach has its strengths and weaknesses.

Impairment approach: Assessing work capacity, on this approach, is entirely a matter of measuring the severity of an underlying health condition and associated impairments. Although simple and straightforward, and by far the most common approach used worldwide, the Impairment approach has been strongly criticized both technically in terms of reliability and in terms of the underlying assumption that inferences from severity of impairments can validly be made to levels of work capacity, without in any way taking into account the impact that features of the work place environment – how the job is structured, stress levels, the physical conditions, and the social and attitudinal conditions of employment. The interactional model, and evidence supporting it, strongly suggests that this approach is inadequate and distorts the assessment process.

Functional Limitation approach: This approach arose in the 1970s in response to criticism of the Impairment strategy from rehabilitation professionals who argued that physical examination and medical history-taking are an insufficient evidentiary basis for assessing work disability. They argued that a person's work capacity depended on the extent to which the person could perform very basic actions such as lifting, standing, walking, sitting, carrying, pushing, pulling, climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, fingering, talking, feeling, hearing, and seeing. These 'functional capacities' were thought to be essential predictors of work capacity. To assess these capacities a range of Functional Capacity Evaluation (FCE) tools, mostly health condition specific, were developed and recommended for disability assessment.

The Functional approach has been plagued with disappointing results in developing valid and reliable FCEs that have application, not only across health conditions, but internationally. There is also the

concern that FCEs tend to focus on a person's deficits—the capacities that the individual has lost—when it is commonly agreed a person's physical and mental assets and strengths are equally important information for a work disability assessment. Finally, Functional approach suffers from the same problem as the Impairment approach: it only indirectly, by proxy, assesses work disability. Although both information about impairments and functional limitations in the performance of basic activities is essential for disability assessment, especially for work disability, equally important is information about the impact of the working environment on work disability.

Disability approach: The Disability approach attempts to directly assess disability rather than indirectly infer disability from a proxy impairment or functional capacity assessments. Direct assessment, in principle, gives equal consideration to all determinants of disability—medical, functional, environmental and personal. The disability approach, in its purest form, would be fully individualized and based on direct evidence. It would strive to provide valid assessment directly on evidence, on the assumption that the true object of assessment must be the person-environment, interactive outcome rather than any intrinsic feature of the person (impairment or functional capacity).

For many decades, although the Disability approach was acknowledged to be the theoretical optimal approach, it was argued that either the Impairment or the Functional Limitation approaches were preferable, because the very concept of 'disability' remained controversial and it was simply not practically feasible to collect and analyze information about the person (health condition, impairments, and functional limitations) and the person's environment, in order to make a disability assessment. Because of the ICF, however, these objections can be overcome.

Introduction to ICF

In May 2001, the International Classification of Functioning, Disability and Health (ICF) of the WHO was endorsed by the World Health Assembly. The ICF provides a comprehensive and standardized framework and language for the description of Functioning and Disability. The ICF model is the clearest expression of the interactive model of disability about which there is worldwide consensus, as expressed by the World Health Assembly unanimous endorsement. As an international standard, the ICF provides separate classifications of the components of Functioning and Environmental Factors, each of which is composed of domains (chapters and blocks) and categories. Qualifiers are provided to describe the extent of the problems in Functioning, that is, the extent of Disability denoted by each domain and category variable.

'Functioning' in the ICF as an umbrella term including all aspects and dimensions of how human species function and act, from the concrete functions (and structures) of the human body and mind to the variety of simple and complex actions that a person engages in. These simple and complex actions are conceptualized from the perspective of the intrinsic capacities of the person to perform actions (the perspective of **Capacity**), and in terms of the actual performance of these actions in interaction with the complete context in which the person lives (the perspective of **Performance**).

Depending on the dimension of Functioning of interest, Disability is denoted as a matter of Impairments of Body Functions and Body Structures, Limitations in Activities and Restrictions in Participation. Functioning and Disability are thus overarching terms that identify these parallel dimensions. Although Functioning is conceptually linked to a health condition (a disease, disorder, injury or natural process such as aging), it is not a direct causal consequence but rather the overall experience of living with a health condition. The key issue is that Disability is created both by the underlying Health Condition and associated Impairments and by the lowered or raised levels of Capacity to perform Activities & Participation that result from Environmental Factors. **Health state and environmental factors are therefore both determinants of Disability**.

Application of ICF to disability assessment

There is a growing recognition that disability assessment should be based on the full, contextualized lived experience of health rather than merely on diagnosis, impairments or functional capacity evaluation. Increasingly, researchers and policymakers have turned to the ICF as a feasible design framework for reforming disability assessment procedures for social, health, and employment policy.

The fact that ICF is a globally accepted, international standard classification generates three sources of added value in the application of the ICF as a design framework for disability assessment:

ICF is an optimal data reporting structure: As ICF is a complete information collection structure, with an exhaustive and mutually exclusive list of domains of functioning, it offers the prospect of providing the full range and detail of information required for a complete disability assessment. Moreover, ICF not only coordinates existing data, it identifies informational gaps, in particular information about the work environment that, as has been shown, greatly enhances the validity and reliability of work disability determination.

ICF is the basis for process legitimacy: Standardization of process, procedure and evidence is the administrative solution to challenges to legitimacy, and this is what the ICF can provide. Documentation of information in the language of ICF not only guarantees comparability, it also secures accountability. As the internationally accepted, scientific basis for describing the determinants and outcomes of functioning, disability and health, ICF is the optimal basis for making the case for the legitimacy of a disability assessment procedure.

ICF is an international platform for assessment and measurement: Recent work on the development of ICF Core Sets and other breakthroughs in measurement strategies relying on ICF as an exhaustive, and consistent, classification of all domains of Functioning and Environmental Factors, have led to useable instrumentation with direct application to disability assessment.

ICF and the paradigm shift in disability assessment

The ICF can be seen as providing a profound paradigm shift in our understanding of the rationale for, and importance of disability assessment in the context of disability policy, worldwide.

First, ICF makes it feasible to construct a complete functioning profile for the purposes of assessment, based not merely on what a person cannot do, but including their assets and strengths. Added to this is ICF's capacity to systematically record the presence of environmental facilitators and barriers, and their impact on the person performance in his or her actual context, and ICF makes it possible to directly assess disability.

Second, ICF, for the first time, creates the conceptual and practical structure to predict disability trajectories over time in order to be able to flexibly respond to changing social circumstances. Predicting how disability plays out in a person's life over time is not only beneficial for anticipating economic and social costs of disability, it also makes it possible to implement health and rehabilitation (including vocational) interventions that can, for example by building on a person's assets and strengths, untouched by a chronic health condition, limit the overall impact of health problems. Essentially, it can help keep a person on the job, instead of leaving the labor market. With demographic ageing, it is becoming increasingly important to identify, and if possible, modify, ageing trajectories as individuals age into, or age with, chronic health conditions.

Third, the fundamental ICF distinction between capacity and performance makes it possible to identify and target interventions that are key to programs such as return to work. An ICF-based disability assessment points us toward both sets of determinants of disability – intrinsic health conditions and

impairments, on the one hand, and environmental factors on the other. Rehabilitation therapists have traditionally adopted this understanding of disability in their work, looking both at interventions that enhance a person's capacity, and at ways of improving performance by means of environmental facilitators, from assistive technology to workplace modifications

Finally, to complete the potential paradigm shift that ICF promises, an ICF-based design framework for disability assessment has clear social and ethical significance that reaches far beyond procedural and scientific adequacy. Specifically, the need for a complete—asset as well as deficit—profile and the requirement that information about the potential impact of environmental adjustment on improved performance, in the workplace and across all areas of social and personal life, are consistent with the human rights found in various Articles and provisions of the United Nations' Convention on the Rights of Persons with Disabilities.

The fundamental lesson that ICF teaches in the context of disability assessment is this: Ensuring equality of capacity across the citizenry is beyond human knowledge and ingenuity: people will always be intrinsically, and often irremediably, different in the health conditions they experience, their impairments and functional deficits and assets. People have different Functioning profiles and there is only so much humans can do medically and therapeutically to 'equalize' human capacity in general or work capacity in particular. Performance is a different matter. Although there are many practical reasons why achieving equalized work performance is also beyond our grasp, it is not an impossibility: the working environment, across the labor market, could in principle be made fully accessible to all workers, whatever their Functioning profile. If achieving this goal is unfeasible, striving for it is a plausible policy objective; indeed, according to the Convention on the Rights of Persons with Disabilities, it is a matter of basic human rights.

Conclusion

A design framework for disability assessment grounded in the model and classifications of the ICF provides the basis for realizing the Disability approach to disability assessment. The case for moving beyond the purely Impairment and Functional Limitation approaches to the Disability approach for disability assessment is clear and persuasive. There is strong procedural, conceptual and normative arguments for moving toward the Disability strategy. The ICF provides not only the conceptual and practical tools for implementing the Disability strategy, it does so based on a globally accepted international standard. While there is no simple, one-size-fits-all ICF template that can transform a country's disability assessment and evaluation procedures into those that implement the full Disability approach, the ICF provides the conceptual basis and standard language needed to design the required assessment instruments and documentation tools to bring this about. All that is required is the political will to move in what is clearly the scientifically and ethically proper direction in the reform of disability assessment.

ANNEX 2: DISABILITY DATA

Table 1: Number of people with disabilities 2008-2018

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total											
Adults only	**121,118**	**130,430**	**139,797**	**144,695**	**149,662**	**156,099**	**161,741**	**168,015**	**174,628**	**179,781**	**184,575**
Severity of disability											
Very severe disability	13,610	15,717	17,177	17,822	19,020	20,965	23,024	24,605	25,862	26,529	27,135
Severe disability	67,700	71,932	75,137	75,893	77,007	79,053	80,480	82,358	84,519	85,901	87,213
Moderate disability	42,190	45,592	50,703	54,368	56,633	59,024	61,266	64,011	67,105	70,257	73,196
Children	**7,222**	**7,251**	**7,230**	**7,721**	**8,358**	**8,870**	**8,354**	**8,412**	**8,407**	**8,356**	**8,312**
Gender (Adults)											
Male	65,663	69,824	73,904	75,689	77,771	80,749	82,540	85,113	87,799	89,686	91,430
Female	62,677	67,857	73,123	76,727	80,249	84,220	87,555	91,314	95,236	98,451	101,457
Age											
Children	**7,222**	**7,251**	**7,230**	**7,721**	**8,358**	**8,870**	**8,354**	**8,412**	**8,407**	**8,356**	**8,312**
Working age	88,524	93,550	99,396	101,923	104,047	106,669	107,940	109,929	112,073	113,060	113,816
Retirement age	32,594	36,880	40,401	42,772	45,615	49,430	53,801	58,086	62,555	66,721	70,759

Source: MOW, Welfare Information System, Data for all periods updated in June 2019.

Table 2: Number of people applying for disability assessment 2008-2018

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total											
First time	**11,565**	**14,228**	**15,464**	**14,679**	**15,091**	**16,749**	**16,699**	**17,309**	**17,883**	**16,975**	**16,949**
Repeat assessment	**24,857**	**25,960**	**27,322**	**29,033**	**30,125**	**32,501**	**34,837**	**35,820**	**37,394**	**42,000**	**38,467**

Source: MOW, Welfare Information System, Data for all periods updated in June 2019.

Table 3: Number of people applying for disability assessment for the first time by ICD codes

		2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Certain infectious and parasitic diseases	**A00-B99**	**284**	**308**	**344**	**346**	**390**	**361**	**406**	**355**	**368**	**274**	**269**
Tuberculosis	A15-A19; B90	185	195	192	182	221	181	202	157	159	123	127
Chronic viral hepatitis C	B18.2	19	19	34	48	44	46	80	73	62	42	36
Human immunodeficiency virus [HIV] disease	B20-B24	51	40	49	56	64	78	89	91	104	74	72
Malignant	**C00-C97**	**2,723**	**3,120**	**3,063**	**3,099**	**3,492**	**3,642**	**3,809**	**3,808**	**3,799**	**3,768**	**3,834**
Malignant neoplasm of prostate	C61	204	245	262	263	287	362	375	431	411	429	425
Malignant neoplasm of colon	C18-C21	311	340	335	340	423	448	451	439	431	427	447
Malignant neoplasm of bronchus	C34	269	311	278	288	328	356	352	370	327	348	394
Malignant neoplasm of breast	C50	527	542	507	552	619	595	677	623	633	679	653
Benign	**D10-D36**	**71**	**100**	**101**	**75**	**81**	**78**	**72**	**73**	**76**	**65**	**67**
Benign neoplasm of meninges and of brain and other parts of central nervous system	D32-D33	54	78	73	51	52	58	47	53	49	54	38

Uncertain or unknown behavior	**D37-D48**	**17**	**30**	**42**	**37**	**33**	**36**	**50**	**65**	**70**	**65**	**69**
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	**D50-D89**	**26**	**30**	**27**	**30**	**32**	**31**	**29**	**38**	**36**	**32**	**27**
Endocrine, nutritional and metabolic diseases	**E00-E90**	**260**	**343**	**356**	**316**	**309**	**348**	**329**	**362**	**374**	**369**	**340**
Diabetes mellitus	E10-E14	209	274	294	252	251	283	265	302	294	295	284
Mental, Behavioral and Neurodevelopmental disorders	**F00-F99**	**834**	**1,027**	**1,256**	**1,183**	**1,236**	**1,302**	**1,340**	**1,289**	**1,456**	**1,380**	**1,372**
Organic, including symptomatic, mental disorders	F00-F09	289	342	445	545	614	635	722	774	918	914	943
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20-F29	392	513	585	437	399	400	372	325	340	293	263
Diseases of the nervous system	**G00-G99**	**710**	**868**	**942**	**981**	**919**	**977**	**982**	**933**	**919**	**863**	**814**
Parkinsonism	G20	112	136	171	182	163	200	188	186	201	177	178
Multiple sclerosis	G35	63	67	80	96	64	62	82	76	56	63	50
Epilepsy	G40	67	98	117	132	86	89	98	94	68	77	49
Diseases of the eye and adnexa	**H00-H59**	**337**	**483**	**463**	**513**	**530**	**636**	**691**	**689**	**726**	**695**	**682**
Diseases of the ear and mastoid process	**H60-H95**	**18**	**31**	**53**	**39**	**52**	**60**	**55**	**56**	**52**	**52**	**41**
Conductive and sensorineural hearing loss	H90	15	17	27	26	32	33	40	42	35	35	27
Other and unspecified hearing loss	H91	3	10	21	9	15	20	8	7	11	9	4
Diseases of the circulatory system	**I00-I99**	**2,840**	**3,098**	**3,395**	**3,167**	**3,279**	**3,872**	**3,803**	**4,033**	**4,176**	**3,958**	**3,756**
Ischaemic heart disease	I20-I25	460	601	663	650	620	746	731	786	866	800	831

Cardiomyopathy	I42	126	145	145	136	140	180	138	169	193	155	134
Cerebrovascular disease	I60-I69	1,663	1,598	1,841	1,677	1,784	2,114	2,123	2,193	2,216	2,030	1,924
Atherosclerosis of native arteries of the extremities	I70.2	220	227	194	189	205	246	204	230	199	210	166
Diseases of the respiratory system	**J00-J99**	**157**	**205**	**260**	**203**	**222**	**213**	**216**	**204**	**230**	**222**	**207**
Asthma	J45	62	104	175	112	108	95	87	85	86	70	63
Diseases of the digestive system	**K00-K93**	**232**	**263**	**245**	**217**	**196**	**238**	**219**	**231**	**213**	**222**	**191**
Diseases of liver	K70-K77	125	145	136	114	98	98	107	108	90	82	94
Diseases of the skin and subcutaneous tissue	**L00-L99**	**20**	**41**	**39**	**32**	**26**	**33**	**26**	**41**	**37**	**41**	**45**
Psoriasis	L40	14	20	26	24	15	22	15	28	30	30	35
Diseases of the musculoskeletal system and connective tissue	**M00-M99**	**1 418**	**2 086**	**2 596**	**2 339**	**2 438**	**2 873**	**2 765**	**3 081**	**3 167**	**3 029**	**3 064**
Osteoarthritis of hip	M16	213	272	297	299	287	315	318	359	352	364	391
Osteoarthritis of knee	M17	131	178	182	172	185	218	261	278	285	279	308
Deforming dorsopathies, spondylopathies and other dorsopathies	M40-M54	798	1,258	1,615	1,396	1,505	1,732	1,572	1,850	1,850	1,703	1,654
Diseases of the genitourinary system	**N00-N99**	**131**	**154**	**162**	**179**	**166**	**181**	**166**	**179**	**191**	**192**	**179**
Chronic kidney disease	N18-N19	71	80	113	113	118	118	111	119	135	131	138
Pregnancy, childbirth and the puerperium	**O00-O99**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**
Certain conditions originating in the perinatal period	**P00-P96**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Congenital malformations, deformations and chromosomal abnormalities	**Q00-Q99**	**47**	**61**	**53**	**65**	**69**	**74**	**81**	**66**	**89**	**69**	**67**
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	**R00-R99**	**0**	**0**	**0**	**1**	**2**	**0**	**0**	**1**	**2**	**6**	**5**
Injury, poisoning and certain other consequences of external causes	**S00-T98**	**1,441**	**1,988**	**2,058**	**1,860**	**1,611**	**1,784**	**1,654**	**1,792**	**1,880**	**1,630**	**1,877**
Injuries of eye	S05; T90.4	87	98	114	81	67	88	61	62	54	64	61
Burn and corrosion confined to eye and adnexa	T26	0	0	0	0	0	0	1	0	0	1	0
Factors influencing health status and contact with health services	**Z00-Z99**	**4**	**6**	**11**	**9**	**16**	**22**	**29**	**41**	**42**	**51**	**63**
Accidents and supplementary factors related to causes of morbidity and mortality classified elsewhere	**V01-Y98**	**0**	**1**	**1**	**2**	**6**	**1**	**1**	**1**	**2**	**6**	**6**
Other diseases			**1**	**1**	**0**	**4**	**1**	**0**	**0**	**5**	**5**	**5**

Source: MOW, Welfare Information System, Data for all periods updated in June 2019.

Table 4: Number of people applying for re-assessment by ICD codes (repeated)

		2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Certain infectious and parasitic diseases	**A00-B99**	**523**	**541**	**547**	**594**	**600**	**664**	**734**	**785**	**762**	**835**	**668**
Tuberculosis	A15-A19; B90	352	346	323	350	308	332	331	339	301	319	230
Chronic viral hepatitis C	B18.2	50	60	60	74	98	86	115	131	144	142	118
Human immunodeficiency virus [HIV] disease	B20-B24	38	50	61	58	75	107	140	196	206	251	232
Malignant	**C00-C97**	**4,122**	**4,254**	**4,595**	**4,508**	**4,989**	**5,461**	**5,997**	**6,207**	**6,385**	**7,323**	**6,705**

Malignant neoplasm of prostate	C61	212	253	315	351	426	508	575	617	675	829	762
Malignant neoplasm of colon	C18-C21	361	385	450	409	519	535	639	625	673	788	746
Malignant neoplasm of bronchus	C34	218	206	283	245	247	286	303	350	345	395	336
Malignant neoplasm of breast	C50	1,194	1,218	1,231	1,157	1,254	1,386	1,432	1,513	1,519	1,725	1,612
Benign	**D10-D36**	**232**	**227**	**245**	**242**	**250**	**283**	**249**	**269**	**250**	**279**	**242**
Benign neoplasm of meninges and of brain and other parts of central nervous system	D32-D33	166	158	181	177	180	197	182	201	178	219	168
Uncertain or unknown behavior	**D37-D48**	**56**	**58**	**52**	**64**	**84**	**72**	**91**	**109**	**117**	**171**	**141**
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	**D50-D89**	**86**	**100**	**83**	**88**	**79**	**86**	**100**	**88**	**106**	**102**	**89**
Endocrine, nutritional and metabolic diseases	**E00-E90**	**724**	**775**	**754**	**806**	**781**	**850**	**932**	**960**	**966**	**1,056**	**971**
Diabetes mellitus	E10-E14	581	654	612	663	653	685	750	789	774	840	769
Mental, Behavioral and Neurodevelopmental disorders	**F00-F99**	**3,911**	**3,621**	**3,656**	**4,051**	**4,053**	**3,629**	**3,412**	**3,033**	**3,060**	**3,525**	**3,403**
Organic, including symptomatic, mental disorders	F00-F09	840	766	812	872	949	926	948	889	998	1,170	1,184
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20-F29	1,968	1,887	1,881	2,077	1,989	1,769	1,624	1,371	1,267	1,464	1,333
Diseases of the nervous system	**G00-G99**	**1,743**	**1,903**	**1,842**	**1,956**	**1,973**	**2,133**	**2,316**	**2,301**	**2,436**	**2,627**	**2,229**
Parkinsonism	G20	85	98	119	125	142	186	231	232	234	280	241
Multiple sclerosis	G35	269	267	260	262	237	291	269	301	300	316	270

Epilepsy	G40	258	299	269	302	309	295	339	319	350	358	287
Diseases of the eye and adnexa	**H00-H59**	**878**	**713**	**778**	**800**	**910**	**1,074**	**1,055**	**1,020**	**983**	**1,134**	**1,300**
Diseases of the ear and mastoid process	**H60-H95**	**66**	**64**	**74**	**64**	**70**	**80**	**88**	**82**	**93**	**108**	**102**
Conductive and sensorineural hearing loss	H90	43	41	47	41	47	60	63	59	71	71	65
Other and unspecified hearing loss	H91	13	22	19	19	14	10	10	10	9	19	20
Diseases of the circulatory system	**I00-I99**	**4,325**	**4,506**	**4,737**	**5,032**	**5,290**	**6,067**	**6,572**	**6,951**	**7,204**	**7,932**	**7,108**
Ischaemic heart disease	I20-I25	1,123	1,235	1,249	1,402	1,494	1,550	1,738	1,798	1,907	2,161	1,928
Cardiomyopathy	I42	264	267	264	308	319	348	365	369	403	431	402
Cerebrovascular disease	I60-I69	1,644	1,648	1,897	2,007	2,154	2,734	2,920	3,211	3,256	3,583	3,201
Atherosclerosis of native arteries of the extremities	I70.2	322	287	285	257	280	324	340	342	374	355	342
Diseases of the respiratory system	**J00-J99**	**530**	**576**	**540**	**552**	**511**	**538**	**582**	**604**	**591**	**630**	**558**
Asthma	J45	334	356	306	370	336	329	342	330	317	325	267
Diseases of the digestive system	**K00-K93**	**444**	**487**	**488**	**530**	**494**	**479**	**512**	**516**	**569**	**591**	**514**
Diseases of liver	K70-K77	198	214	231	240	223	183	205	178	210	223	182
Diseases of the skin and subcutaneous tissue	**L00-L99**	**49**	**63**	**73**	**92**	**85**	**86**	**83**	**94**	**96**	**113**	**105**
Psoriasis	L40	32	37	51	50	57	55	52	60	68	84	79
Diseases of the musculoskeletal system and connective tissue	**M00-M99**	**3,239**	**3,608**	**4,150**	**4,888**	**5,361**	**6,052**	**6,796**	**7,402**	**7,939**	**9,167**	**8,072**
Osteoarthritis of hip	M16	495	484	512	532	589	623	718	746	842	980	891

Osteoarthritis of knee	M17	218	257	294	330	351	415	480	568	618	711	719
Deforming dorsopathies, spondylopathies and other dorsopathies	M40-M54	1,726	1,977	2,400	2,940	3,246	3,769	4,135	4,532	4,806	5,596	4,775
Diseases of the genitourinary system	**N00-N99**	**344**	**400**	**364**	**383**	**352**	**427**	**418**	**450**	**426**	**449**	**378**
Chronic kidney disease,	N18-N19	125	156	175	171	162	237	228	269	244	259	235
Pregnancy, childbirth and the puerperium	**O00-O99**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Certain conditions originating in the perinatal period	**P00-P96**	**3**	**2**	**2**	**1**	**0**	**0**	**1**	**1**	**2**	**0**	**0**
Congenital malformations, deformations and chromosomal abnormalities	**Q00-Q99**	**357**	**388**	**345**	**362**	**328**	**320**	**369**	**334**	**321**	**360**	**321**
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	**R00-R99**	**0**	**0**	**1**	**0**	**0**	**0**	**2**	**2**	**4**	**5**	**4**
Injury, poisoning and certain other consequences of external causes	**S00-T98**	**3,302**	**3,742**	**4,102**	**4,100**	**4,007**	**4,288**	**4,641**	**4,721**	**5,222**	**5,876**	**5,690**
Injuries of eye	S05; T90.4	59	45	67	40	50	42	65	44	40	28	40
Burn and corrosion confined to eye and adnexa	T26	2	0	1	0	1	1	1	2	1	1	0
Factors influencing health status and contact with health services	**Z00-Z99**	**10**	**18**	**31**	**37**	**21**	**40**	**40**	**76**	**78**	**99**	**113**
Accidents and supplementary factors related to causes of morbidity and mortality classified elsewhere	**V01-Y98**	**0**	**0**	**1**	**3**	**3**	**4**	**1**	**3**	**2**	**6**	**4**
Other diseases		**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**5**	**7**

Children:

		2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total		**7,222**	**7,251**	**7,230**	**7,721**	**8,358**	**8,870**	**8,354**	**8,412**	**8,407**	**8,356**	**8,312**
Certain infectious and parasitic diseases	**A00-B99**	**46**	**33**	**36**	**38**	**40**	**58**	**64**	**61**	**56**	**55**	**54**
Human immunodeficiency virus [HIV] disease	B20-B24	14	15	16	18	17	22	26	31	32	35	40
Malignant neoplasms	**C00-C97**	**153**	**177**	**193**	**220**	**227**	**249**	**229**	**224**	**227**	**226**	**233**
Benign neoplasms	**D10-D36**	**18**	**22**	**26**	**28**	**29**	**33**	**27**	**22**	**24**	**20**	**19**
Neoplasms of uncertain or unknown behavior	**D37-D48**	**6**	**6**	**6**	**7**	**8**	**10**	**9**	**8**	**6**	**5**	**5**
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	**D50-D89**	**44**	**50**	**60**	**75**	**85**	**95**	**92**	**94**	**98**	**108**	**111**
Endocrine, nutritional and metabolic diseases	**E00-E90**	**337**	**387**	**414**	**503**	**574**	**636**	**638**	**670**	**690**	**714**	**738**
Diabetes mellitus	E10-E14	232	258	275	338	388	432	447	469	485	512	534
Mental and behavioral disorders	**F00-F99**	**1,350**	**1,511**	**1,675**	**1,931**	**2,149**	**2,324**	**2,181**	**2,286**	**2,348**	**2,348**	**2,422**
Mental retardation	F70-F79	1,057	1,183	1,320	1,515	1,647	1,734	1,577	1,611	1,643	1,599	1,596
Pervasive developmental disorders	F84	85	114	134	163	206	258	304	372	428	475	574
Diseases of the nervous system	**G00-G99**	**761**	**951**	**1,070**	**1,206**	**1,313**	**1,340**	**1,230**	**1,203**	**1,180**	**1,160**	**1,160**
Epilepsy	G40	163	201	209	225	250	247	205	222	211	199	198
Cerebral palsy	G80	341	449	532	607	654	656	612	579	564	535	527
Diseases of the eye and adnexa	**H00-H59**	**245**	**271**	**278**	**271**	**276**	**282**	**253**	**244**	**231**	**218**	**207**

Diseases of the ear and mastoid process	**H60-H95**	**215**	**344**	**429**	**464**	**493**	**517**	**469**	**460**	**465**	**483**	**485**
Conductive and sensorineural hearing loss	H90	191	315	405	442	472	493	447	440	445	464	470
Other hearing loss	H91	21	27	23	20	19	21	18	16	16	15	11
Diseases of the circulatory system	**I00-I99**	**31**	**40**	**39**	**45**	**45**	**49**	**40**	**36**	**32**	**33**	**39**
Diseases of the respiratory system	**J00-J99**	**372**	**352**	**340**	**330**	**336**	**331**	**291**	**268**	**266**	**207**	**128**
Asthma	J45	366	347	333	323	327	315	281	256	252	198	119
Diseases of the digestive system	**K00-K93**	**40**	**41**	**37**	**46**	**53**	**53**	**46**	**55**	**51**	**50**	**55**
Diseases of the skin and subcutaneous tissue	**L00-L99**	**23**	**26**	**25**	**29**	**37**	**44**	**53**	**50**	**48**	**51**	**47**
Diseases of the musculoskeletal system and connective tissue	**M00-M99**	**299**	**340**	**392**	**475**	**571**	**649**	**627**	**630**	**574**	**528**	**484**
Juvenile arthritis	M08	124	145	204	282	354	415	420	440	409	369	333
Scoliosis	M41	25	28	26	31	41	41	35	33	28	25	23
Juvenile osteochondrosis of hip and pelvis	M91	61	71	74	73	76	73	69	59	55	46	49
Diseases of the genitourinary system	**N00-N99**	**65**	**74**	**74**	**79**	**87**	**86**	**79**	**82**	**86**	**73**	**75**
Pregnancy, childbirth and the puerperium	**O00-O99**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Certain conditions originating in the perinatal period	**P00-P96**	**13**	**14**	**10**	**13**	**15**	**15**	**9**	**12**	**14**	**28**	**24**
Congenital malformations, deformations and chromosomal abnormalities	**Q00-Q99**	**1,292**	**1,545**	**1,688**	**1,823**	**1,917**	**1,980**	**1,862**	**1,880**	**1,884**	**1,922**	**1,917**
Congenital malformations of the circulatory system	Q20-Q28	264	294	288	292	280	304	277	262	259	245	241
Congenital malformations and deformations of the musculoskeletal system	Q65-Q79	221	268	298	327	370	381	350	368	353	359	344

Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	**R00-R99**	**0**	**0**	**0**	**0**	**1**	**1**	**1**	**1**	**1**	**4**	**3**
Injury, poisoning and certain other consequences of external causes	**S00-T98**	**127**	**135**	**142**	**157**	**175**	**180**	**143**	**116**	**118**	**112**	**106**
Injury of eye and orbit	S05; T90.4	26	38	46	45	48	48	41	35	37	35	26
Burns and corrosions confined to eye and internal organs	T26	0	0	0	0	0	0	0	0	0	0	0
Factors influencing health status and contact with health services	**Z00-Z99**	**2**	**2**	**3**	**6**	**7**	**8**	**9**	**8**	**6**	**6**	**8**
External causes of morbidity and mortality	**V01-Y98**	**0**	**0**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
Other		**1,819**	**1,020**	**373**	**55**	**28**	**29**	**19**	**18**	**17**	**10**	**1**

Source: MOW, Welfare Information System, Data for all periods updated in June 2019.

Table 5: Number of people applying for disability assessment by severity (first time)

	2008	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Very severe disability	2,718	2,772	3,285	3,547	4,001	4,749	5,062	5,073	5,111	4,817	4,579
Severe disability	5,714	3,839	6,599	6,123	6,256	6,647	6,438	6,817	6,974	6,549	6,761
Moderate disability	3,024	4,486	5,448	4,904	4,714	5,252	5,090	5,355	5,738	5,552	5,538

Source: MOW, Welfare Information System, Data for all periods updated in June 2019.

Table 6: Number of people applying for disability re-assessment by severity

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Very severe disability	2,637	2,594	3,105	3,475	3,931	5,293	5,858	6,012	6,216	6,577	6,503
Severe disability	13,458	14,202	14,012	14,236	14,407	15,174	15,693	15,890	16,503	18,556	16,216
Moderate disability	8,479	8,920	10,006	11,126	11,602	12,023	13,308	14,018	14,782	17,460	15,894

Source: MOW, Welfare Information System, Data for all periods updated in June 2019.

Table 7: Description of Severity of disability by ICD Codes (2018)

		First time assessment				**Re-assessment**			
		Total	**Very severe**	**Severe disability**	**Moderate disability**	**Total**	**Very severe**	**Severe disability**	**Moderate disability**
			4,579	**6,761**	5,538		**6,503**	**16,216**	15,894
Certain infectious and parasitic diseases	**A00-B99**	**269**	**8**	**177**	78	**523**	**39**	**275**	361
Tuberculosis	A15-A19; B90	127	**1**	**108**	14	352	**5**	**97**	134
Chronic viral hepatitis C	B18.2	36	**2**	**21**	13	50	**6**	**45**	68
Human immunodeficiency virus [HIV] disease	B20-B24	72	**3**	**32**	35	38	**17**	**91**	124
Malignant	**C00-C97**	**3,834**	**1,319**	**2,283**	215	**4,122**	**1,434**	**3,463**	1,879
Malignant neoplasm of prostate	C61	425	**100**	**286**	39	212	**107**	**479**	181
Malignant neoplasm of colon	C18-C21	447	**195**	**247**	5	361	**221**	**414**	124
Malignant neoplasm of bronchus	C34	394	**220**	**169**	5	218	**152**	**143**	45
Malignant neoplasm of breast	C50	653	**85**	**521**	43	1 194	**193**	**761**	684

Benign	**D10-D36**	**67**	**9**	**34**	23	**232**	**29**	**132**	83
Benign neoplasm of meninges and of brain and other parts of central nervous system	D32-D33	38	**5**	**19**	14	166	**22**	**94**	52
Uncertain or unknown behavior	**D37-D48**	**69**	**14**	**33**	22	**56**	**15**	**90**	37
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	**D50-D89**	**27**	**3**	**17**	6	**86**	**4**	**39**	45
Endocrine, nutritional and metabolic diseases	**E00-E90**	**340**	**44**	**114**	179	**724**	**140**	**430**	390
Diabetes mellitus	E10-E14	284	**36**	**93**	152	581	**118**	**331**	315
Mental, Behavioral and Neurodevelopmental disorders	**F00-F99**	**1,372**	**687**	**475**	180	**3,911**	**721**	**2,076**	471
Organic, including symptomatic, mental disorders	F00-F09	943	**677**	**209**	54	840	**504**	**515**	144
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20-F29	263	**6**	**190**	46	1,968	**63**	**1,079**	116
Diseases of the nervous system	**G00-G99**	**814**	**195**	**271**	343	**1,743**	**495**	**946**	785
Parkinsonism	G20	178	**85**	**73**	20	85	**136**	**94**	14
Multiple sclerosis	G35	50	**3**	**15**	31	269	**74**	**104**	87
Epilepsy	G40	49	**0**	**11**	37	258	**9**	**114**	159
Diseases of the eye and adnexa	**H00-H59**	**682**	**202**	**264**	216	**878**	**469**	**580**	254
Diseases of the ear and mastoid process	**H60-H95**	**41**	**0**	**2**	39	**66**	**0**	**5**	97
Conductive and sensorineural hearing loss	H90	27	**0**	**1**	26	43	**0**	**2**	63
Other and unspecified hearing loss	H91	4	**0**	**0**	4	13	**0**	**0**	20
Diseases of the circulatory system	**I00-I99**	**3,756**	**1,514**	**1,526**	716	**4,325**	**2,037**	**3,454**	1,659

Ischaemic heart disease	I20-I25	831	**84**	**420**	327	1,123	**107**	**1,091**	742
Cardiomyopathy	I42	134	**19**	**88**	27	264	**40**	**279**	83
Cerebrovascular disease	I60-I69	1 924	**1,130**	**613**	181	1,644	**1,564**	**1,225**	422
Atherosclerosis of native arteries of the extremities	I70.2	166	**57**	**96**	13	322	**112**	**190**	45
Diseases of the respiratory system	**J00-J99**	**207**	**23**	**91**	93	**530**	**58**	**277**	226
Asthma	J45	63	**1**	**16**	46	334	**11**	**107**	149
Diseases of the digestive system	**K00-K93**	**191**	**19**	**108**	61	**444**	**42**	**269**	204
Diseases of liver	K70-K77	94	**15**	**62**	16	198	**26**	**113**	43
Diseases of the skin and subcutaneous tissue	**L00-L99**	**45**	**0**	**11**	34	**49**	**3**	**49**	51
Psoriasis	L40	35	**0**	**8**	27	32	**1**	**38**	39
Diseases of the musculoskeletal system and connective tissue	**M00-M99**	**3,064**	**243**	**892**	1,924	**3 239**	**458**	**2,785**	4,876
Osteoarthritis of hip	M16	391	**45**	**197**	149	495	**94**	**427**	382
Osteoarthritis of knee	M17	308	**29**	**121**	158	218	**52**	**331**	342
Deforming dorsopathies, spondylopathies and other dorsopathies	M40-M54	1,654	**62**	**348**	1,241	1,726	**128**	**1,318**	3,361
Diseases of the genitourinary system	**N00-N99**	**179**	**116**	**44**	16	**344**	**194**	**144**	40
Chronic kidney disease	N18-N19	138	**104**	**26**	6	125	**151**	**74**	9
Pregnancy, childbirth and the puerperium	**O00-O99**	**2**	**1**	**1**	0	**0**	**0**	**0**	0
Certain conditions originating in the perinatal period	**P00-P96**	**0**	**0**	**0**	0	**3**	**0**	**0**	0
Congenital malformations, deformations and chromosomal abnormalities	**Q00-Q99**	**67**	**3**	**19**	45	**357**	**38**	**102**	159

Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	**R00-R99**	**5**	**2**	**1**	2	**0**	**1**	**1**	2
Injury, poisoning and certain other consequences of external causes	**S00-T98**	**1,877**	**169**	**364**	1,331	**3,302**	**316**	**1,058**	4,332
Injuries of eye	S05; T90.4	61	**1**	**2**	58	59	**11**	**7**	22
Burn and corrosion confined to eye and adnexa	T26	0	**0**	**0**	0	2	**0**	**0**	0
Factors influencing health status and contact with health services	**Z00-Z99**	**63**	**6**	**29**	28	**10**	**15**	**59**	40
Accidents and supplementary factors related to causes of morbidity and mortality classified elsewhere	**V01-Y98**	**6**	**1**	**5**	0	**0**	**3**	**1**	0
Other diseases		**5**	**4**	**1**	0	**0**	**1**	**3**	3

Table 8: Annual income by individuals who have been registered in the register of the State Social Insurance Agency in 2018

			Very severe disability	**Severe disability**	**Moderate disability**
Total	N	**61,355**	**1,680**	**21,460**	**38,215**
	Mean (SD)	**6322,88 (7220.63)**	**4712.14 (6829.99)**	**5685.33 (6433.75)**	**6751.71 (7608.45)**
	Median (Min-Max)	**5144.56 (0.19-837375.55**	**2778.73 (5.50-109327.28)**	**4373.32 (0.19-172714.40)**	**5465.98 (0.94-837375.55)**
	IQR	**2042.17-8462.20**	**873.39 – 6007.75**	**1499.95 - 7602.46**	**2551.17 – 8962.65**
Disabled since childhood	N	**21,484**			
	With income	**7,606**	**202**	**2,581**	**4,823**
	Mean (SD)	**6460.07 (6780.92)**	**519.53 (6241.42)**	**5194.67 (6006.37)**	**7191.71 (7080.16)**

	Median (Min-Max)	**5159.61 (3.59-127794.08)**	**3192.60 (6.00-32531.83)**	**4054.00 (5.31-127794.08)**	**5640.47 (3.59-108012.02)**
	IQR	**1856.08-8640.00**	**743.80-6846.01**	**1364.72 – 7069.94**	**2339.81-9685.13**
Disability acquired during working age	N	**99094**	**1104**	**14878**	**28884**
	Mean (SD)	**2519.31 (4150.04)**	**4112.94 (4044.16)**	**5198.16 (4317.02)**	**6096.99 (4411.73)**
	Median (Min-Max)		**2865.10 (17.00-19516.56)**	**4459.09 (0.19-199650.51)**	**5404.38 (0.94-19992.66)**
	IQR		**904.65-5957.02**	**1598.47-7532.44**	**2588.80-8639.84**
Disability at retirement age	N	**75,448**			
		7,504	**347**	**3,527**	**3,630**
	Mean (SD)	**5254.05 (6335.36)**	**4267.79 (9206.67)**	**4760.49 (5756.34)**	**5827.88 (6484.42)**
	Median (Min-Max)	**3830.55 (1283.73)**	**2093.69 (5.50-109327.28)**	**3172.29 (5.00-86880.55)**	**4661.86 (5.12-102087.51)**
	IQR	**1283.73-7055.73**	**720.00-4802.20**	**1067.21-6502.19**	**1686.77-7749.59**

Source: MOW, Welfare Information System, Data for all periods updated in June 2019.

Table 9: Benefits per year by individuals who have been registered in the register of the State Social Insurance Agency on 2018

			Very severe disability	Severe disability	Moderate disability
Total	N	**193,104**	**30,984**	**87,057**	**75,063**
	Mean (SD)	**3048.58 (2049.89)**	**4181.42 (2124.40)**	**3078.02 (1848.98)**	**2546.84 (2049.34)**
	Median (Min-Max)	**2799.22 (0.65-21757.05)**	**4226.04 (0.65-18858.03)**	**2947.68 (0.95-21757.10)**	**1810.44 (2.16-21560.73)**
	IQR	**1370.73-4092.46**	**2558.97-5881.86**	**1647.00-92-3835.58**	**927.72-3631.44**
Disabled since childhood	N	**21485**	**3458**	**9700**	**8327**
	Mean (SD)	**2580.21 (1425.93)**	**4272.99 (1546.45)**	**2480.14 (1152.28)**	**1993.81 (1077.59)**
	Median (Min-Max)	**2202.66 (0-13091.27)**	**4226.04 (41.31-13036.02)**	**2155.76 (0-13091.27)**	**1499.61 (6.89-11445.41)**
	IQR	**1536.72 – 3437.27**	**3659.59 -4966.46**	**1536.72-3227.67**	**1280.64-2433.60**
Disability acquired during working age	N	**99,094**			
		96,818	**6,403**	**41,279**	**49,136**
	Mean (SD)	**2444.18 (230.12)**	**3600.30 (2286.35)**	**2692.55 (1968.51)**	**2084.88 (1956.87)**
	Median (Min-Max)	**1802.19 (0.65-21751.08)**	**3517.76 (0.65-18483.26)**	**2370.09 (0.95-21751.08)**	**1252.14 (2.16-21560.73)**
	IQR	**957.61-3190.16**	**1665.81-5145.12**	**1315.59-3310.95**	**842.16-2624.23**
Disability at retirement age	N	**75,448**			

		74,806	**21,123**	**36,083**	**17,600**
	Mean (SD)	**3965.15 (1885.17)**	**4342.58 (2124.74)**	**3679.30 (1682.89)**	**4098.19 (1877.45)**
	Median (Min-Max)	**3731.21 (6.37-21757.05)**	**4584.15 (8.99-18858.03)**	**3557.78 (6.37-21757.05)**	**3802.49 (8.56-19415.80)**
	IQR	**3011.75-4912.92**	**2814.33-6003.96**	**2972.46-4186.85**	**3161.34-4732.58**

Source: SSIA

ANNEX 3: Key Legislative Acts Pertaining to Disability

Laws

Convention on the Rights of Persons with Disabilities 2006. United Nations. Available at: Available at: https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

1. The Constitution of the Republic of Latvia 1922. Riga: Saeima. Available at: https://likumi.lv/ta/id/57980-latvijas-republikas-satversme
2. Disability Law 2010. Riga: Saeima. Available at: https://likumi.lv/ta/id/211494-invaliditates-likums
3. Education Law 1998. Riga: Saeima. Available at: https://likumi.lv/ta/id/50759-izglitibas-likums
4. General Education Law 1999. Riga: Saeima. Available at: https://likumi.lv/ta/id/20243-visparejas-izglitibas-likums
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ANNEX 4: Pedagogical medical commission and special education programs

One of the most important documents for a child with special needs to receive education is an opinion of the Pedagogical Medical Commission (PMC) of the state or local government. The PMC is a body that decides on the necessity of a special education program for a particular learner. The competence of pedagogical medical commissions, professional requirements for members of the commission, as well as the criteria according to which they provide opinions are determined by the Cabinet regulation.[222]

According to the Regulation, the local government pedagogical medical commission issues an opinion on the child's most relevant preschool education program or special preschool education program; a general primary education program for grades 1 to 4 and a special primary education program for children with mental disorders, severe mental disorders or multiple severe mental disorders, learning difficulties, language impairments or mental health disorders from grades 1 to 4; in other cases an opinion is issued by the state pedagogical medical commission. The Commission should include teachers, psychologists, speech therapists and medical doctors. The Regulation specifies necessary competences for the members of the pedagogical medical commission (Table 1).

Table A4.1: Qualification requirements for members of the pedagogical medical commission

Member of the commission	Education	Experience	Additional conditions
Head of the commission	Higher education in special pedagogy, educational psychology, clinical psychology, speech therapy or pedagogy	At least three years` experience in special pedagogy	-
Member of the commission	Master's degree in clinical or educational psychology (the level five of professional qualification)	At least three years of experience in the diagnosis of the intellectual capacity and emotional condition of learners	1. A right to use at least one of the intellectual capacity tests adapted and standardized in Latvia 2. At least one member of the commission
Member of the commission	Higher education in speech therapy	At least three years of work experience in speech therapy	At least one member of the commission
Member of the commission	Higher education in special pedagogy	At least three years' working experience in the special pedagogy	At least one member of the commission
Member of the commission	Certified medical practitioner (doctor)	-	At least one member of the commission

[222] Regulations on Pedagogical Medical Commissions. 2012. SI 2012/709. Riga: Cabinet of Ministers. Available at: https://likumi.lv/doc.php?id=252162

The opinion of pedagogical medical commissions is based on the child's medical diagnosis for which a specialist opinion with a specified term of validity is required. For example, a child with progressive cataract (H26.0) needs an ophthalmologist's opinion issued not earlier than six months before the commission meeting.[223] This implies that the ability of a child to learn/ participate in an education program is determined based on medical diagnosis not on her/ his actual ability to learn.

Data from all PMCs are stored and kept by the National Centre for Education. They include (i) personal information (given name, surname, personal identity number, etc.); (ii), information on the results of the child's pedagogical, psychological and medical examination; (iii) recommendations on the necessity of support measures in the training process and the state tests; (iv) information on the child's health, capacity and the need for re-evaluation of the level of development. The personal file is deleted a year after information has been received that the educational institution has issued a document to the child regarding the acquisition of the proposed education program or the acquisition of secondary education.

The data kept at the National Centre for Education comprises information form PMC only. This reflects a situation of fragmented information space in Latvia where all sectors - education, healthcare, disability, social services – have their own data systems, which do not talk to each other. The result is that the same information is requested repeatedly (opinions, examinations, consultations) leading to unnecessary spending of scarce resources and a significant burden on beneficiaries who are asked to provide information. The solution is simple – a systematic exchange of information between various government data bases. This should be easy to achieve, as all citizens of Latvia have their individual personal identification numbers.

Once the recommendation of PMC is received, parents try to enroll their children in school. According to the General Education Law, the local government head of general education is responsible for the identification of the special needs of the learners and their education in accordance with the specified requirements of the special education program.[224] If a primary or general secondary education institution cannot meet the requirements specified by the Cabinet, it may refuse to admit the learner. In such cases, the director informs in writing the applicant (parents) and the relevant local government, specifying the reasons for the refusal. The local government should, if necessary, provide parents with information regarding vacancies in other educational institutions in the administrative territory of the local government.

It is important to point out that the remuneration of teachers in special preschool education groups and special education groups in general education institutions is financed from the state budget and state budget earmarked subsidy[225].

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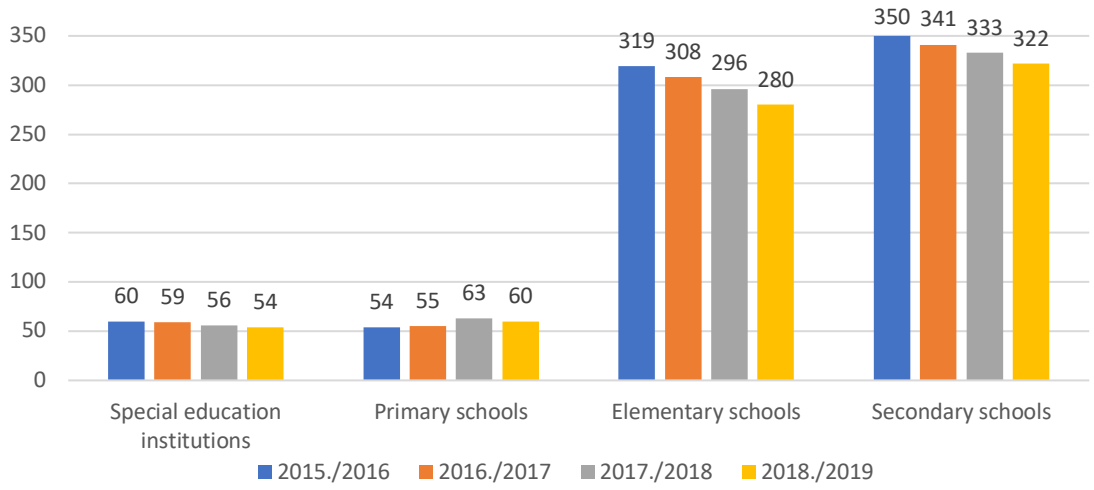
[223] For example, for a child with a severe sensorineural hearing impairment (5th degree: no verbal language development), an opinion of several specialists is required, incluidng an otorhinolaryngologist, an audiologist and an audio speech therapist or a speech therapist, and a psychologist, in some cases a child neurologist/ neurologist is consulted as well. The term of validity of the opinion of the psychologist is one year before the meeting of the commission, the term of the opinion of other specialists is six months. A child with cerebral stroke and other paralytic syndromes (G80–G83) should have an opinion of a child neurologist or a neurologist verified by an opinion of radiological (confirmed by the radiologist), functional or other objective method of examination, which should be issued not earlier than six months prior to the commission meeting; furthermore, if the commission is repeated an assessment of the dynamics of the rehabilitation process is required. A child with childhood autism (F84.0) or atypical autism (F84.1) or Asperger's syndrome (F84.5), if her/his level of development of intellectual capabilities is below the theshold for mental retardation, requires an opinion of a child psychiatrist/ psychiatrist issued not earlier than three months before the commission meetings.

[224] General Education Law 1999. (s.11), Riga: Saeima. https://likumi.lv/ta/id/20243-visparejas-izglitibas-likums

[225] Ibid, (s.60). https://likumi.lv/ta/id/20243-visparejas-izglitibas-likums

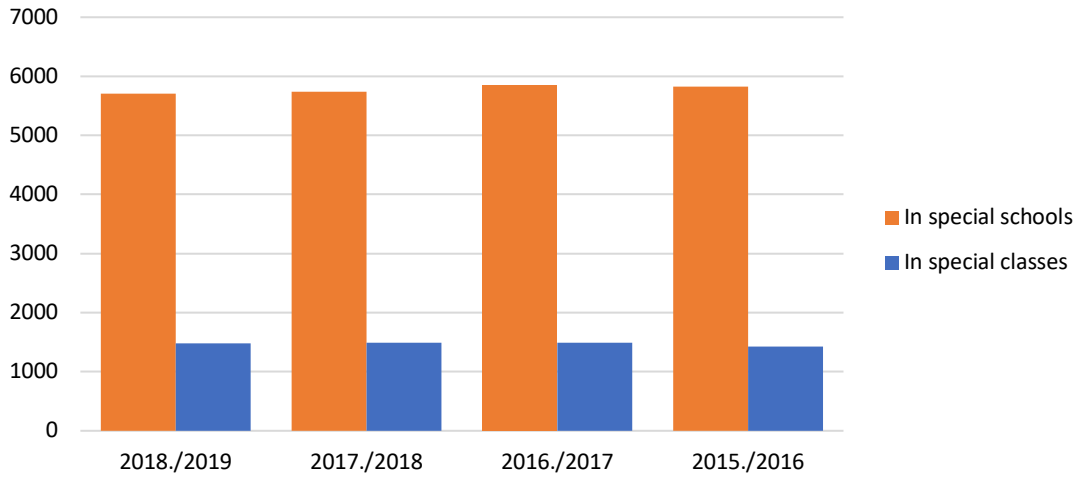
Figure A4.1: Number of educational institutions in Latvia



Source: Official statistics on general education. Ministry of Education and Science226

Special schools still play an important role in general education (figures A4.1 and A4.2): most of the students – as many as 80.0 percent are educated in special schools. Only 20.0 percent is enrolled in special classes in regular schools. No information on students with disabilities included in regular classes is available. The data suggest that inclusive education is not an approach perused in education in Latvia.

Figure A4.2: Number of students in special schools and special classes



Source: Official statistics on general education. Ministry of Education and Science [227]

The fundamental issue remains the quality of education for children with disabilities. PMC recommends education program by diagnosis, not learner's capacity; special schools, i.e. segregated education system prevails; data on education for children with disabilities are scarce; the funding, which is shared between the state and local governments is not enough to ensure support needed by learners with special education needs, etc. In some situations, local governments are only in theory

[226] Official statistics on general education. Ministry of Education and Science. Available at: https://izm.gov.lv/lv/publikacijas-un-statistika/statistika-par-izglitibu/statistika-par-visparejo-izglitibu.
[227] Official statistics on general education. Ministry of Education and Science. Available at: https://izm.gov.lv/lv/publikacijas-un-statistika/statistika-par-izglitibu/statistika-par-visparejo-izglitibu

responsible for providing education for children with disabilities residing on their territories - as soon as the child “falls out” from the general education system, it is the parents’ responsibility.

Moreover, neither the Professional Education Law, nor the Law on Higher Education Institutions provide for persons with special needs. Nor are statistical data available about learners with special needs who acquire vocational or higher education. Only Professional Education Law stipulates that the costs for the acquisition of a vocational education and vocational qualification of students with special needs are covered from the state budget, if they are residents in special education institutions.[228] Information on how many learners acquire vocational education in such classes, how many and in which schools such classes have been established, what the employment rates after the acquisition of education are, etc. is not publicly available.

[228] Vocational Education Law 1999. (s.31 (4) 1), Riga: Saeima. Available at: https://likumi.lv/ta/id/20244-profesionalas-izglitibas-likums

ANNEX 5 - Assessment of functioning

Items included in the self-assessment form:

Understanding and communication:

1. focus on work for 10 minutes;
2. remember to do something important;
3. analyze and deal with everyday problems;
4. master a new task, for example, to get to previously unknown place;
5. understand words of other people;
6. communicate with strangers;
7. understand people close to you;
8. talk and negotiate;

Mobility:

9. vertical positioning (for example, standing, walking) for longer period (30 minutes);
10. stand up from the sitting position;
11. move through the dwelling;
12. move out from the dwelling;
13. go out for 200 meters;

Self-care:

14. wash;
15. dress;
16. eat;
17. stay alone for a few days;

Home life and work:

18. carry out main household tasks;
19. job performance (if person is employed).

Abilities of functioning are assessed for the following ICF categories:

1. Specific mental functions

1.1. b140 attention functions;
1.2. b144 Memory functions
1.3. b164 Higher-level cognitive functions

2. Sensory functions and pain

2.1. b280 Pain

3. Functions of the cardiovascular, hematological, immunological and respiratory systems

3.1. b455 Exercise tolerance functions

4. Neuromusculoskeletal and movement related functions

4.1. b710 Mobility of joints
4.2. b730 Muscle power functions

5. Learning and applying knowledge

5.1. d155 Acquiring skills
5.2. d177 Making decisions

6. Communication

6.1. d399 Communication unspecified

7. Mobility

7.1. d410 Changing basic body position
7.2. d415 Maintaining a body position
7.3. d430 Lifting and carrying objects
7.4. d440 Fine hand use
7.5. d445 Hand and arm use
7.6. d450 Walking

8. Self-care

8.1. d510 Washing oneself
8.2. d540 Dressing
8.3. d550 Eating
8.4. d598 Self-care other specified

9. Interpersonal interactions and relationships

9.1. d720 Complex interpersonal interactions

ANNEX 6: Disability Assessment and Disability Information System

In this annex, first, we describe and assess the information technology system (ITS) that supports disability assessment processes (following a step-by-step business and administrative processes), including electronic information flow and how it supports decision making. We look at the ITS from the point of view of usability for beneficiaries – is the system accessible on-line and to what extent? Is it usable by assessment officers? We also assess the adequacy of the IT system for process monitoring and report generation and whether all processes are automated or whether some are handled manually. Second, we discuss how well the disability assessment system is integrated into other relevant sources of information and government databases, focusing on the following: 1) the extent to which information on sick leave, as well as medical information is interoperable/ available to all decision-makers involved in disability assessment; 2) protection of data confidentiality; and 3) information gaps in the disability assessment process, e.g. relevant information needs to be obtained in paper or other non-electronic formats. Finally, we assess the integration of the disability assessment system with other relevant information systems as they concern disability policy and benefits – health and rehabilitation, labor market inclusion, social security, etc. We identify problems and gaps in the system and propose steps to make the system more effective, user friendly and supportive of both beneficiaries and service providers.

Information obtained during the disability and predictable disability assessment process is processed and stored in the SMC Information System (SMC IS), according to Cabinet Regulation No 381 "Regulation on Disability Information System".[229]

The current SMC IS was developed in 2006, with upgrades in 2011 and 2015. However, relative to actual needs and requirements, it is outdated, and it does not comply with the good practice of the person data processing regulations. SMC IS is integrated only with The Office of Citizenship and Migration Affairs, from which civil registry type of information about the person is provided. The information from/to other institutions is provided by data file exchange using predefined data files and copying them to SFTP servers or by selecting data from the SMC database, using Web services. The existing system doesn't have an integration with National Electronic Health Record System (E-health).

Currently, there is an ongoing project to update SMC IS (2019-2022), that will significantly change the overall approach, ensuring the system that is based and developed on business processes and providing necessary access to data, as well as the storage of personal information according to requirements of The General Data Protection Regulation. The new system development follows an iterative approach: first reworking and providing existing and necessary functionality (the first half of the 2020); then during the 2nd and 3rd rounds of the project, the additional functionality and necessary data exchange, as well as improved e-services will be developed.

i. Application for the assessment

The assessment application forms (paper or electronically signed document) are available on the SCM web page in the section "Necessary documents for the assessment" (http://www.vdeavk.gov.lv/ekspertizei-nepieciesamie-dokumenti/):

- The form in case a person fills out the application herself/himself: http://www.vdeavk.gov.lv/wp-content/uploads/2015/01/IESNIEGUMS-V1_09_2018_vers3.docx;

[229] Ministru Kabinets. 20.08.2019 Noteikumi Nr.381 "Invaliditātes informatīvā sistēma". https://likumi.lv/ta/id/308895-invaliditates-informativas-sistemas-noteikumi

- The form in case the application is filled out by the person's trustee: http://www.vdeavk.gov.lv/wp-content/uploads/2015/01/IESNIEGUMS-V2_09_2018_slegts.docx.

The person must provide the following information in the ***application***:

1. Information about the person: name, surname, personal code, state of citizenship, address, telephone and email address.

2. The choice of assessment, marking from the following options:

    a. Predictable disability assessment;
    b. Disability and work-ability assessment;
    c. Other (describing the need).

3. Attached documents, marking from the following options:

    a. Referral to SMC;
    b. Self-assessment of Functioning Abilities;
    c. Photo 3x4xcm or a digital photo;
    d. Additional documents (describing the documents);

4. Preferable way to receive the certificate (SMC decision), marking from the following:

    a. In person, in the SMC client service;
    b. By post to the following address (stating the address);
    c. In the SMC client service to issue to the following person – and state the person's name, surname and personal identification number.

5. Date and signature.
6. In the case if application is filled out by the person's trustee, in addition, there is a section with information about the trustee:

    a. The name, surname, personal code, telephone and e-mail address;
    b. Type of representation: the parent of the child, guardian, attorney, trustee.

The application can be submitted also by using e-service (the link to e-service is provided in section "E-services" http://www.vdeavk.gov.lv/e-pakalpojumi/) and choosing the e-service "EP62 Submission to the State Medical Commission for the Assessment of Health Condition and Working Ability to make the disability assessment".

To use the e-service person has to use one of the supported authentication methods (eId, eSignature or one of the provided i-bank authorizations). After the authentication, there are 5 following steps to perform to submit the application:

1. Choose: submitting application for itself or on behalf of the person s/he represents;
2. Choose: create a new document, or an existing draft (if there is previously created but not submitted draft);
3. Provide information about needed assessment by choosing the appropriate checkbox, mark the documents that are submitted with the application and upload them as files (the allowed file formats are: *.edoc – for digitally signed documents; *.zip; *.pdf; *.doc or *.docx.).
4. Choose the kind of assessment (Mental, eyesight or others) and the place of assessment (one of the 9 departments). After choosing the place of assessment, if the department provides

information about available assessment dates and time – the possibility to choose the date and time is offered. It should be noted that this is an old feature – disability assessment does not require a face to face interview any longer. This feature causes confusion.

5. Submit the application.

When the application is submitted using the e-service, it is sent automatically to SMC IS. Currently, the e-service has two key shortcomings:

1. The application cannot be submitted if a person doesn't choose the location (department) where the face to face assessment meeting will take place. The e-service was not adjusted for the change in the process that does not require a face to face interview any longer.
2. Language barriers for persons not speaking Latvian: although the portal provides options to choose the language (Latvian, Russian and English, only some fields are displayed in other languages; most functionality is available only in Latvian.

When applicant (person, trustee or treating doctor) submits person's application to SMC, the next process is the processing of received document by client service employee of SMC.

ii. Application processing at SMC and designation of SMC expert/assessor

1. If an application is submitted using the e-service, then the application and attached files are available in SMC IS. An SMC clerk selects "new applications" in the IS and start reviewing them;
2. If an application is submitted in person, via post or via email, the clerk first must register the application in the SMC IS, and only then review submitted documents. To register new application in SMC IS, the following steps are followed:
   a. Find the person by her/his personal identification number in SMC IS. If the person had been registered with IS, the clerk updates the person's data from the Office of Citizenship and Migration Affairs (OCMA) data base.
   b. If a person is new to SMC IS, the clerk must first register her/him by requesting his/her data from the OCMA using the person's personal code. The clerk then adds data from the application.
   c. If the data are not provided from OCMA due to technical problems, the clerk can enter personal data manually. In other cases, if OCMA cannot provide information, the clerk must contact the applicant to verify the person's unique identifier, or to clarify other information.
3. After the application has been recorded in SMC IS, the clerk reviews the application and attached documents and checks if all required documents are included (i.e. a medical referral to SMC and a self-assessment of functioning abilities):
   a. If the application is in order, a clerk opens a new case for disability determination (registering a new case in SMC IS, and preparing a paper file with all submitted documents). If documents were submitted electronically using e-service, the clerk prints out submitted documents and attaches them to the application in the person's paper file);
   b. If any document is missing, or there is need for more information, a clerk informs a person and the case is "on hold" until the required documents are provided.
4. If the application is for the predicted disability assessment, a clerk checks whether a rehabilitation plan has been submitted. If not, the clerk informs the applicant about the need to provide it;
5. If the application is for an assessment of disability combine with a request for special care services, the SMC clerk sends a request to a relevant municipal social worker or an ergo therapist from the municipal social service office (municipal specialist) to fill out a questionnaire on the activities of daily leaving and the environment:

a. The questionnaire is available as a MS Word Document on SMC web page, as well as methodological guidance on how to fill it out: http://www.vdeavk.gov.lv/personas-ikdienas-aktivitasu-un-vides-novertejums/
b. The purpose of the questionnaire is to provide information to SMC about the person's capacity to function in the home environment, so that SMC expert can make an informed on the need to provide a special care service.
c. According to the methodological guidelines, a municipal specialist, after having received a request from SMC, contacts the person and makes an appointment for a home visit to conduct the assessment (if a person is in the long-term care institutions, then the interview takes place in the institution).
d. During the assessment, the specialist observes the person's capacity to function, assesses the person's environment and interprets not only information provided verbally by the person, but also non-verbal information – the observed feelings and behaviors of the person.
e. The specialist fills out the questionnaire and sends it to SMS, or hands it over to the person to submit to SMC.

6. When all requested information is received, the SMC clerk hands over the case to an SMC official.
7. The SMC official reviews the case, chooses the kind of assessment (general or special) and appoints an SMC expert who will process the case. The expert/assessor is chosen based on the workload of available experts.
8. After the SMC expert has been designated, that information is recorded in SMC IS and the expert receives the case (paper file with all the documents).

iii. Assessment

The assessment is carried out according to the SMC Internal Guidelines,[230] which aim to ensure that all experts/ assessors in SMC apply Disability Assessment Criteria stipulated by the Regulation 805 from the Cabinet of Ministers[231] in the same manner and reach similar assessment. Guidelines provides explanation of used terms, criteria for predicted disability assessment, criteria for disability assessment and decision on special care service need for personas over 18 years of age, as well as detailed instructions on assessment of health disorders and assessment on functioning abilities.

As Assessment Act includes an assessment of functioning restrictions, the internal guidelines provide detailed information about each criterion used in the Functioning Capability Assessment table, as well as explanation for every criterion value. In addition, experts can use the Manual "Criteria for the Assessment of Health Disorders", providing information of functioning disorders according to the International Classification of Functioning, Disability and Health (ICF) and diagnoses according to the International Classification of Diseases (ICD-10) codes. Manuals are available internally as well as on the SMC home page.[232]

1. At the start of the assessment process, the SMC expert evaluates all documents included in the person's case file, as well as additional information that is registered in SMC IS (for example information on previously made assessments, added documents, decisions, etc.):
   a. If provided information is deemed not sufficient to perform the assessment, the SMC expert may request additional information/ diagnostic procedures from the person's General Practitioner (GP) or a treating doctor.

[230] 17.03.2016 VDEAVK Iekšējie noteikumi "Kārtība, kādā Veselības un darbspēju ekspertīzes ārstu valsts komisija nodrošina Ministru kabineta 2014.gada 23.decembra noteikumu Nr.805 "Noteikumi par prognozējamās invaliditātes, invaliditātes un darbspēju zaudējuma noteikšanas kritērijiem, termiņiem un kārtību"3., 4., 5., un 6.pielikumā noteikto kritēriju piemērošanu".
[231] The Regulations Regarding Criteria, Time Periods and Procedures Determining Predictable Disability, Disability, and the Loss of Ability to Work, 2014. SI 2014/805. Riga: Cabinet of Ministers: https://likumi.lv/ta/id/271253-noteikumi-par-prognozejamas-invaliditates-invaliditates-un-darbspeju-zaudejuma-noteiksanas-kriterijiem-terminiem-un-kartibu
[232] See: http://www.vdeavk.gov.lv/wp-content/uploads/2014/11/2013_Rokasgramatas_1_pielikums_Krit%C4%93riji.doc.

i. If requested information is available, a GP/ treating doctor send it to the SMC expert;
ii. If requested additional diagnostic procedures are available, and acceptable to the patient, the GP/ treating doctor refer the patient to relevant specialists;
iii. If additional diagnostic is not available (due to long waiting lists or other reasons), or unaffordable, the expert can invite the applicant for a face to face interview.

b. If the case is complicated and the expert is not able to make the assessment on her own, s/he informs the SMC official and requests for additional experts to participate in the assessment. The SMC official appoints and informs additional SMC experts/assessors.
c. If the case is ordinary and information is sufficient, the SMC expert conducts the assessment.

2. When all necessary information is provided, the SMC expert reviews documents and decides on whether to conduct the assessment based on documents or to invite the applicant for a face to face interview. The latter is requested in the following cases:
   a. Information is deemed insufficient, but it is not in the person's interest to delay the assessment;
   b. Information is contradictory;
   c. The case is complicated and requires a face to face interview.

If the decision is to perform the assessment with the person's participation, then the SMC expert himself or with the assistance of an SMC clerk, contact the person and agrees on the date and time of the face to face interview.

3. To conclude, the assessment can be conducted (as a default) by the expert alone and only based on documents provided; by a team of experts reviewing the documents (in complex cases) and with the presence of the applicant (in rare cases). During the assessment, the SMC expert evaluates provided information. If the applicant is present, the assessor may ask her/him to provide some additional information or to perform some activities to evaluate her/his health and functioning restrictions.

iv. Assessment act

The information from the assessment is registered in SMC IS by filling out an assessment act. Assessment act comprises the following information:

a. Information about the assessment: the name and surname of the expert/assessor, the date and time of the assessment.
b. Information about the person (mainly automatically filled by the data available in SMC IS, or if these data are not in the system, filled in by the SMC expert):
   i. Name, surname, ID code, address;
   ii. Education level, profession, workplace, type of last employment, count of working hours, the start date of the incapacity to work and the reason, the date and the reason for leaving employment;
   iii. The list of the reviewed documents;
   iv. Person's complaints, opinions and arguments;
   v. Medical history;
   vi. Social and work history;
   vii. Information about diagnoses (primary, secondary, co-morbidities), level of functioning restrictions, complications.
   viii. Ongoing treatment.
c. Information on the health disorder assessment:
   i. Description of symptoms;
   ii. Physical investigation data;
   iii. Laboratory instrumental examination data;

iv. Conclusion on the severity of health disorders with available values: light, moderate, severe and very severe.

d. Information on functioning abilities. Assessment is made for 21 predefined categories. Categories comply with the ICF. For every category, expert must determine the following: a) correlation with the disease – yes or no; b) severity: value from 0 – 4; c) Severity is based upon medical documentation or personal assessment. The predefined ICF categories are:
   - b140 Attention functions;
   - b144 Memory functions;
   - b164 Higher-level cognitive functions;
   - b280 Sensation of pain;
   - b455 Exercise tolerance functions;
   - b710 Mobility of joint functions;
   - b730 Muscle power functions;
   - d155 Acquiring skills;
   - d177 Making decisions;
   - d399 Communication;
   - d410 Changing basic body positions;
   - d415 Maintaining a body position;
   - d430 Lifting and carrying objects;
   - d440 Fine hand use;
   - d445 Hand and arm use;
   - d450 Walking;
   - d510 Washing oneself;
   - d540 Dressing;
   - d550 Eating;
   - d598 Self-care, other specified
   - d720 Complex interpersonal interactions.

In case the expert considers it necessary to provide information on any other, not listed above ICF category, s/he expert can supplement and evaluate two more ICF categories.

Upon completing the assessment and the Assessment Act, the SMC expert submits the information and registers the end of the assessment in SMC IS. After the submission, the SMC expert notifies a SMC official and requests her/him to approve the Assessment Act. The SMC official reviews the Act using SMC IS and:

(i) Approves the Assessment Act; or
(ii) Points out the flaws, mistakes or failures in the Assessment Act and notifies the Expert. Then the expert makes all the necessary corrections in the Assessment Act and re-submits it to the SMC official.

The Assessment Act is stored only in SMC IS. It is not printed out and included in person's paper case file. (In the case of need, there is a possibility to print or download the document – the information will be provided and displayed as the MS Word document.)

v. Final decision

The approved Assessment Act is sent to an SMC official who:

a. Based on the information about the person's health disorder and the functioning ability assessment, decides if the disability will be granted to the person, and on the severity group of disability.
b. If disability is granted, according to the severity of disability and the disease, as well as requested recommendations and person's health and functioning assessment, SMC official

decides on recommendations concerning the requested services (need of special care, need of assistant, need of vehicle adaptation, etc.).

If the SMC official decides to recommend the requested services, the recommendation documents are prepared by choosing the appropriate recommendation form in SMC IS, filling out the form(s) and saving the document(s) in SMC IS.

The Decision on granting Disability and the severity of disability is registered in SMC IS by choosing the decision form and filling it out. The decision comprises the following information:

c. Information about the person who will receive the decision (name, surname, address);
d. The decision number and date (it will be provided when a SMC clerk registers the document);
e. Information about the person assessed for disability – name, surname, personal ID number;
f. Date of documents submission for disability determination;
g. Statement of findings on which the decision of the SMC official is based;
h. Statement of conclusions, based on stated findings;
i. Statement of justification based on which the disability is or is not granted;
j. The decision to reject or grant disability and group of disability severity;
k. Name, surname and signature of the SMC official.

When the all necessary information is entered into SMC IS and all documents are ready for further processing, the SMC official informs a SMC clerk, to prepare and issue documents to the person or his/her trustee.

The SMC clerk registers all documents that will be issued (the decision and recommendations) and prints them. The documents are signed by a SMC official.

If disability is granted, the SMC clerk prepares the Certificate of disability to the person, including disability severity, and enters information about the issued certificate in SMC IS.

When all the documents are ready, a SMC clerk prepares them to be issued in person or sent to the recipient via post.

The final documents are also available electronically in the State run portal Latvija.lv using e-service “My data in SMC” (https://www.latvija.lv/epakalpojumi/ep64/apraksts).

The e-service “My data in SMC” provides information about the Decision, Recommendations and the Certificate of Disability to every person, whose data are available in SMC IS. Access to the e-service and these documents is granted to the person, parents of underage children and the person’s trustee who is registered as such in OCMA.

E-service contains the following documents registered in SMC IS:

1. A Decision on disability determination, Recommendations on vehicle adaptation, and other recommendations. The meta data includes: Number, Disability determination period: beginning and the date, the type of the decision and the decision. By clicking on the selected document more data are displayed as well as the possibility to view and download the documents as a PDF file.
2. Information about the Certificates of Disability – Number, Disability group, Date of issue, Expiration date, Issuer.

The information about how to use the service, as well as information about the data that are provided in the service are available on the e-service web page (by pressing the button “Open user manual”).

There is also an online instruction video that is available on the YouTube https://www.youtube.com/watch?v=hyndgMZyrFg. The information about the e-service "My data in SMC" is available only in Latvian.

When the Disability Determination Case is completed and the information about the assigned disability is approved, the information about the person is electronically submitted to the State Social Insurance Agency (SSIA). The information is automatically selected and send to the SSIA using the SMA IS monitoring process: to share with SSIA information on all persons whose disability has been determined or prolonged, so that they can automatically receive the benefits provided by the SSIA.

vi. Issuance of documents to the applicant

To issue a disability certificate and other SMC decisions/ recommendations to an applicant and to archive the case, the following steps are taken:

To identify the preferred way of receiving documents, a SMC clerk checks the application:

a. If a person wishes to receive the documents in person at a SMC office, the SMC clerk contact the person using provided contact information in the application form (the phone or e-mail) and invites the person to come to the SMC office and receive the documents:
   - When a person visits the SMC client service office, the documents are issued to her/him (or her/his trustee) and s/he makes a record in document issuing registry.
b. If a person wishes to receive documents via post, the SMC clerk prepares the information letter to the person (or the person's trustee) and prepares documents. The letter and the documents are mailed.

2. After the documents have been delivered, the SMC clerk checks the documents in the case file, makes remarks if needed and hands over the case file to the archive.
3. An employee of the SMC Archive reviews the case: (i) if some documents are found missing, s/he informs the SMC clerk; (ii) if the file is in order, s/he enters the information about the received case file in the archive in SMC IS and puts the case on the appropriate shelf of the physical archive.

vii. Grievance redress

If a person disagrees with the decision on disability determination – if disability is not granted, or the person expected a different disability group, s/he can file a complaint within one-month after the decision has been issued. The complaint can be submitted either in person at a SMC office, or using e-service on the state service portal Latvija.lv (https://www.latvija.lv/epakalpojumi/ep63/apraksts). The information on how to use the e-service is available on the e-service page. It is also available on You Tube with instructions on how to use the service and submit a complaint. ((https://www.youtube.com/watch?v=q0wJ-vn0mB8). The information is available only in Latvian, and the YouTube video is based on the previous design of portal Latvia.lv, but the functionality does not significantly differ from the existing portal version, only the link and the "skin" of the page are different.

In the appeal, the person must indicate the decision that is contested and provide justification for the complaint.

The appeal process starts with the complaint:

a. If the complaint is submitted through the e-service, it is automatically registered in SMC IS. A SMC clerk checks the SMC IS daily and should there be a new complaint, s/he prints it;
b. If the complaint is submitted in person or via post, the information is entered into IS by an employee of SMC client service.

The complaint is handed over to the special SMC department – The SMC Appeals and Controls Department. The employee of this department reviews the application, finds the person's case number in SMC IS and request the case from the archive.

The archive employee searches for the requested case, registers the information about the dispensed case and hands it over to an employee of the SMC Appeals and Controls Department.

The head of the SMC Appeals and Controls Department reviews the case and decides on the experts who will be invited to the assessment, as well as decides on the need to invite other – healthcare or independent experts.

Depending on the reasons for the appeal, as well as the documents in contained in the person's case file, the head of the SMC Appeals and Controls Department decides on the type of the assessment: with the person's presence or without.

The head of the SMC Appeals and Controls Department appoints the lead SMC expert who will be responsible for the secondary assessment.

The SMC expert reviews the case and starts disability assessment. The process is the same as described above. The only difference is that the decision on disability determination is made not by the SMC authority, but by the head of SMC Appeals and Controls Department.

Data exchange

Data exchange between SMC and other government agencies institutions and data systems is regulated by the Cabinet Regulation No 381.[233]

According to the regulation, SMC IS currently receives data only from one register – OCMA. The data are received in two ways:

1. The regular data exchange between SMC and OCMA is run on daily bases at night and provides information about persons whose status has changed in OCMA – death, etc.
2. The data actualization for a specific person – is used when the person's data are processed in SMC IS. The user can press the button "Update data from OCMA", and the data are requested online for a specific person by its unique ID code, and updated in SMC IS.

Currently, the data received from OCMA comprises the following: unique ID, name, surname, gender, date of birth, date of death, citizenship status and State, person's status in OCMA (active or passive), address, legal capacity, information about person's trustee (guardian/ trustee: unique ID, name, surname).

According to the regulation and actual situation, data from the SMC IS are provided to several other agencies. There are two ways how the data are provided:

1. The data of all persons in SMC IS – by providing all actual data at the exchange start date and then providing the change monitoring. Providing a data set with all changes registered in the system in the selected period.
2. The request for data of one person by unique ID. The data are selected and provided only for this one person.

[233] 20.0.2019 Ministru Kabineta noteikumi Nr.381 "Invaliditātes informatīvās sistēmas noteikumi".

The way in which the data exchange is conducted (for all persons or only for one specific person) depends on the aim and the service that is provided by the agency/institution, which is the other partner in the data exchange. The data set provided to any institution can be different, depending on the institutions functions and is determined in the Cabinet Regulation. The agencies/institutions that can receive data from SMC IS are the following:

- The Ministry of Welfare;
- The State Social Insurance Agency;
- The State Labor Inspectorate;
- The State Employment Agency;
- The Social Integration State Agency;
- The State Inspectorate for Protection of Children's Right;
- The State Education Quality Service;
- Road Safety Directorate;
- Latvian Association of the Deaf;
- Latvian Association of the Blind;
- Office of the Citizenship and Migration Affairs;
- The State Revenue Service;
- Trade service provider of protected user;
- The Information Centre of the Ministry of the Interior;
- Road Transport Administration;
- National Health Service;
- Motor Insurer's Bureau of Latvia;
- State Probation Service Law;
- Central Finance and Contracting Agency;
- Administration of Maintenance Guarantee Fund;
- Municipalities and the Institutions of municipalities providing services or administrating tax and fees discounts for persons with disabilities;
- Custody courts;
- System operators of electricity distribution;
- The Ministry of Education and Science;
- The NRC "Vaivari";
- Pauls Stradins Clinical University Hospital';
- National Armed Forces.

Public availability of information on disability assessment

The SMC web page provides also information in English, which is not so wide as in Latvian or Russian, but also provide the main information about disability and predictable disability process, as well as the information to applicants to submit to disability assessment. In addition, some most used benefits that person with disability can obtain are mentioned on page.

The information about disability assessment process and required documents, benefits and privileges that person with certain severity disability can obtain are provided on web page of the MOW. In Latvian and Russian, there is a special section on web page "For persons with disability" with detailed and wide information on all topics, information and forms, that have to be filled by applicant or doctors, or social workers, as well as contact information to SMC and hyperlinks to SMC web page and State service portal. Unfortunately, in English there is no information devoted to persons with disabilities. The Ministry of Welfare (MOW) also provides brochures in printed and web accessible formats, with information about available support for persons with disabilities. http://lm.gov.lv/upload/brosura_inval_26092019_PDF.pdf

On the web page of SSIA, in all three languages – Latvian, Russian and English, there is special section "For persons with disabilities" containing detailed information on benefits, compensations and services that are provided to persons with disabilities.

The State service portal www.latvija.lv provides information on all the services that state institutions provide to citizens and residents, as well as about available e-services. Information is provided in Latvian, Russian and English. The service portal does not have special section for people with disabilities as services are classified in sections: social services, family, entrepreneurship, health, rights, etc. Disability services are displayed as subcategories under the sections "Social Services" and "Health". Under the "Social Services" there are 49 types of services, which in their description contain a reference to "persons with disability". Under the "Health" section, there are seven services, including the application for disability assessment.

In the section "e-services", there is a possibility to find services using keywords. By using the option "Click here to find e-services easier", there is a special section for "Disabled persons" in which six e-services are provided, including the "Application for disability examination" and "Application to dispute disability examination decision".

Another service, provide on the state portal www.latvija.lv under the section "My data" is "My data in the State Medical Commission for the Assessment of Health condition and Working Ability".

If choosing any of the listed e-services, there is full information about the service only in Latvian. Information is only partially available in in Russian and English.

Overall, the State Service Portal is difficult to navigate and information on disability is hard to find, especially using different categories and subcategories in which these services are available. The portal cannot be referenced as a source of information about disability assessment process, but only as the gate, using which e-service can be executed, if the applicant knows what kind of service s/he needs.

Gaps in the current disability assessment process

Most applications are submitted in person and in paper form. The process is well established and rather smooth. However, the personal data protection may be an issue as paper documents, including a medical referral to SMC contain sensitive personal information.

The application for the assessment through the e-service, has, as noted, two key issues: (i) the system asks for the appointment location and data, which is not relevant any longer, but the software has not been updated; and (ii) the full information is available in Latvian only. These could be significant obstacles, as only 1.0 percent of all applications for disability assessment are submitting using this mode of application.

Even when applications are submitted electronically, most of the processing is conducted manually and based on paper documents. The applicants have no opportunity to check the status of their applications, or get requests for additional information, or be notified about the process.

If an SMC Expert needs additional information about the person's medical history, s/he must request that information from a medical practitioner who has referred the person to SMC, even in cases when such information is contained in the E-health system. At present, SMC experts do not have access to E-health system. Another issue is that there have been technical difficulties in the E-health system implementation process.

If the SMC expert decides that person ought to undergo additional diagnostic procedures, or consult some medical specialist, the SMC expert cannot refer directly the applicant. The referral can only be done by a GP, which leads to a prolonged disability assessment process.

Information about the person's assessment is available to any user of the SMC IS, not only to the appointed SMC expert. SMC should consider introducing tighter rules about access to this information.

The decision on recommendations for special services is currently not linked electronically to the services requested in the application. The paper documents on recommendations are prepared based only on the SMC official decision.

According to the system processes analysis interviews with the SMC experts, there are several gaps in the information exchange process. Currently information exchange with other government agencies and institutions that contain personal data relevant to disability assessment is limited:

1. Data exchange system does not provide for registration of all processed data, according to the GDPR. At present, there is no possibility for an individual to request and receive information about registries that contain her/his data: who, when and for what purposes requested and processed the data.
2. There is no possibility for SMC to use the person's passport or ID card photo that is stored in the OCMA system. Having this possibility will eliminate the need for a person to submit a photo to SMC. Instead the photograph stored in the OCMA system could be used for the disability certificate, which is issued in a plastic card format.
3. There is no data exchange between SMC and E-health system. The exchange will eliminate the need for medical referral and other medical documents to be submitted in paper form, as all information, including a medical referral to SMC and personal medical history should be available in E-health system. Likewise, SMC should automatically provide information on the person's disability, severity of disability, duration of disability, recommendations for services, etc. to relevant government agencies and institutions. An integrated information system across government will significantly decrease transaction cost to beneficiaries, who are asked to submit and resubmit same documents in paper form repeatedly.

Planned improvements in the future

As noted, SMC IS is undergoing renewal and update. According to the technical specification of the project, the following improvements are planned.[234]

- E-services will be actualized to the current normative regulation.
- E-services will be re-designated, according to the guidelines on e-services issued by the State Regional Development Agency and the 04.07.2017 Cabinet Regulation No. 402 "Regulations Regarding the Public Administration E-services".[235]
- E-services will be improved by including a functionality that will enable a feedback to a service user, as well as transparency in the service provision.
- The update will provide wider possibilities to submit e-documents.
- The E-services will be provided not only using desktop E-services, but also using mobile applications.

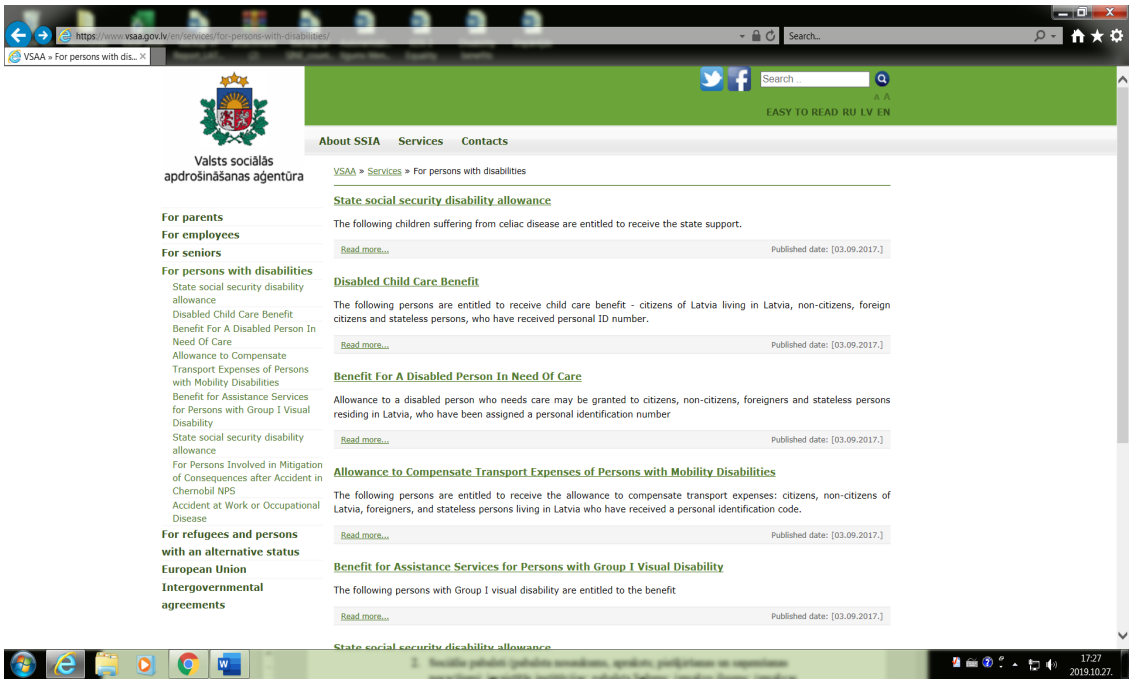
[234] Tehniskā specifikācija – darba uzdevums "Veselības un darbspēju ekspetīzes ārstu valsts komisijas Invaliditātes informatīvās sistēmas pilnveidošanai", Rīga, 2018.

[235] Ministru Kabinets. 04.07.2017 Noteikumi Nr.402 "Valsts pārvaldes e-pakalpojumu noteikumi". https://likumi.lv/ta/id/292261-valsts-parvaldes-e-pakalpojumu-noteikumi

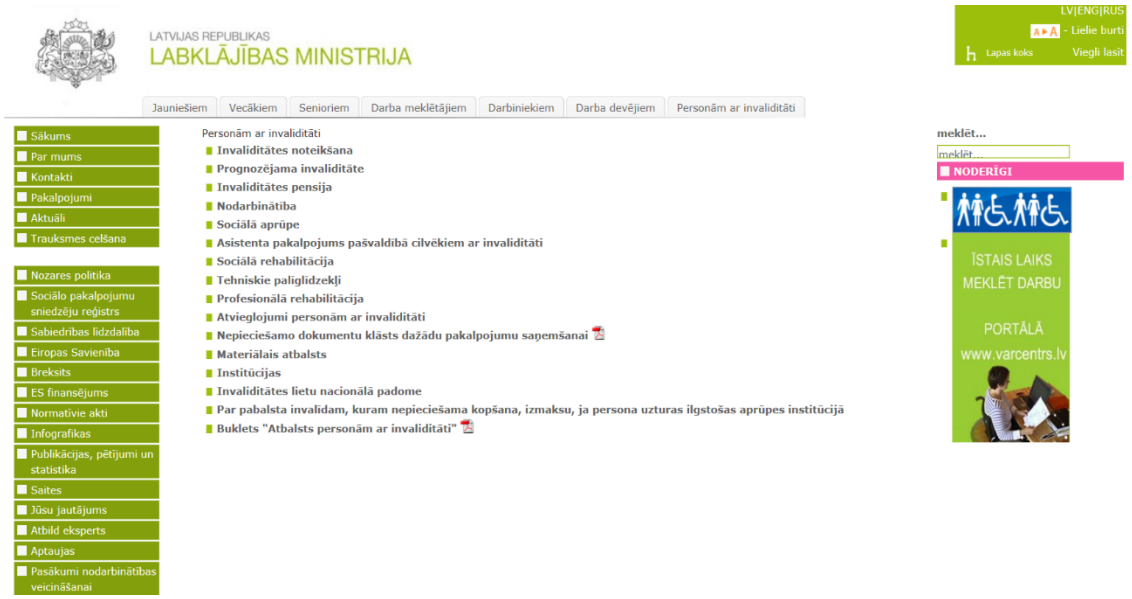
- The new system will significantly change how documents are processed in the system – all files will be organized only electronically; in cases when documents are received on paper in the SMC Client Service or via post, the SMC employee will scan and upload them into the system.
- All documents will be processed only in SMC IS; any access to documents will be recorded in the system log files, to provide information on who, when and in which process requested or edited data in the case file.
- Data exchange with OCMA will be improved, including enabling the use of the persons' photographs used in passports or identification cards by OCMA.
- The assignment of cases to SMC experts will become automated: an SMC official will see the list of available experts sorted by open assessment cases and could choose the expert with the highest availability to work on new cases.
- Access to case information will be limited only to SMC experts and officials whose duties require to work with this information, thus improving the privacy protection of personal information;
- The SMC IS will be integrated with the E-health system.
- The wider use of the E-health system, as it was planned - will provide information about electronic referrals and diagnostic results, as well as laboratory test results. These were planned to be introduced in 2018 but are yet to become mandatory. Referrals to laboratory tests and test results are planned to be introduced over 2020.
- Integration with the E-health system will enable SMC experts to refer applicants to additional medical diagnostic/ consultations.
- There are planned built- in controls to provide better outcomes and controls in cases when the recommendations on special services have to be prepared, to avoid errors.
- All documents will be prepared electronically and signed using e-signature, providing more effective and efficient way of processing documents. In cases, when persons would want to receive paper documents, they will be printed out from the system, and approved by a SMC clerk.
- As documents will be prepared as electronic documents, the integration with the e-address will be provided, to send the documents to the person's profile in the state-run portal Latvija.lv, if the person has activated the e-address account.

ANNEX 7: Information on disability issues

Information on disability pensions and state social benefits is available on the homepage of SSIA in sections "For seniors" and "For persons with disabilities" (in Latvian "Personām ar īpašām vajadzībām").[236]



The home page of MOW contains the section "Persons with Disabilities",[237] which includes information on support/ programs for persons with disabilities.



[236] Homepage of SSIA. October 2019. https://www.vsaa.gov.lv/pakalpojumi/personam-ar-ipasam-vajadzibam/

[237] Homepage of the Ministry of Welfare. October 2019. Available at: http://lm.gov.lv/lv/personam-ar-invalidati

Information about municipal benefits is available on the home pages of respective municipalities. For example, the section “Information for People with Disabilities” on the homepage of the Welfare Department of the Riga City Council.[238]

[238] Welfare Department of the Riga City Council. October 2019. Available at: http://www.ld.riga.lv/lv/socialie-pakalpojumi-102/socialie-pakalpojumi-49/informacija-cilvekiem-ar-invaliditati.html

ANNEX 8: State Allowances and Benefits

1. Allowance for a Child with Disabilities

Legislation that regulates it
The Law on State Social Allowances.[239] *Regulations Regarding the Amount of the Family State Benefit and the Supplement to the Family State Benefit for a Disabled Child, the Review Procedure Thereof, and the Procedures for Granting and Payment of the Benefit and Supplement.*[240]
Description of the benefit
Regular monthly payment to support families with disabled children incurring additional expenditures due to the child's disability.
Eligibility conditions
General requirements to receive state social benefit. Raising a child for whom SMC has determined disability.
Regulating agency
Saeima / Cabinet of Ministers / Ministry of Welfare
Implementing agency
State Social Insurance Agency
The level of the benefit
EUR 106.72 per month
Benefit duration and application renewal requirements
The allowance is granted for the established period of disability until the day when the child with disability reaches 18 years of age. Renewal/continuation requirement: the SMC decision on the determination of disability.
Administrative process and decision-making process to acquire the benefit
SMC determines a disability and provides SSIA with digital information about the child with disability. The child's parents/guardians apply for the allowance according to general procedure. The application is reviewed, and decision to grant/decline the allowance is made within ten days after the has been received.
Grievance and redress mechanisms
General procedures for appeal and contesting of decisions.
Benefit delivery/payment frequency

[239] The Law on State Social Allowances 2002. (s.6), Riga: Saeima. Available at: https://likumi.lv/ta/id/68483-valsts-socialo-pabalstu-likums

[240] Regulations Regarding the Amount of the Family State Benefit and the Supplement to the Family State Benefit for a Disabled Child, the Review Procedure Thereof, and the Procedures for Granting and Payment of the Benefit and the Supplement, 2009. SI 2009/1517. Riga: Cabinet of Ministers. Available at: https://likumi.lv/doc.php?id=202676

Once a month by transfer to the recipient's bank/ post system account.

The payment of the allowance is terminated:

- in general cases;

- if the term of the disability has expired;

- if a child is placed in the state, local government or private childcare and educational institution and is fully maintained by the institution or is in a foster family;

- if a special decision of the orphan's court is made to protect the interests of the child by terminating the payment of the allowance to a person who is not actually caring for and raising the child.

- if custody rights are suspended or deprived of.

Monitoring arrangements

Data are stored in SSIA database. When necessary, the analysis of data is provided by SSIA, Ministry of Welfare

Financing agency

State Treasury

Sources of financing

State basic budget

Number of beneficiaries 2016 - 2019

Year	The total number of beneficiaries[241]
August 2019	7,784
January 2019	7,723
2018	7,723
2017	7,746
2016	7,769

[241] SSIA. "Budget and Statistics". November 2019. Available at: https://www.vsaa.gov.lv/par-vsaa/parmums/

2. Disabled Child Care Benefit

Legislation that regulates it

The Law on State Social Allowances.[242] *Regulations Regarding the Amount of the Disabled Child Care Benefit, the Procedures for the Review Thereof, and the Procedures for Granting and Payment of the Benefit.*[243]

Description of the benefit

State support in cash in a situation when additional expenditures are necessary for the family of a child with disability for whom SMC has issued an opinion on the necessity of special care.

Eligibility conditions

General requirements to receive state social benefit.

A person who raises a child with disability for whom the SMC has issued an opinion on the necessity of special care.

Regulating agency

Saeima / Cabinet of Ministers / Ministry of Welfare

Implementing agency

State Social Insurance Agency

The level of the benefit

EUR 313.43 (from July 2019) per month.

Benefit duration and application renewal requirements

The benefit is granted for the established period of disability and the necessity for special care until the day when the child with disability reaches 18 years of age.

Renewal/continuation requirement: SMC decision on the determination of disability and the necessity for special care.

Administrative process and decision-making process to acquire the benefit

SMC determines disability, provides an opinion on the necessity of special care and provides SSIA with digital information about the child with disability and necessity of special care.

One of parents/ guardian/ adoptive parent/ foster parent requests the benefit according to general procedure.

The application is reviewed, and decision made to grant/decline the benefit within a month after receiving the application.

Grievance and redress mechanisms

General procedures for appeal and contesting of decisions.

Benefit delivery/payment frequency

[242] Ibid. (s.7[1]).

[243] Regulations Regarding the Amount of the Disabled Child Care Benefit, the Procedures for the Review Thereof, and the Procedures for Granting and Payment of the Benefit, 2009. SI 2009/1607. Riga: Cabinet of Ministers. Available at: https://likumi.lv/doc.php?id=202852&from=off

Once a month to the recipient's bank/post system account.

The payment of the benefit is terminated:

- in general cases;

- if the term of disability and necessity of special care have expired;

- if the child reaches18 years of age;

- if the child is placed in the state, local government or private childcare and educational institution and is fully maintained by the institution or is in a foster family;

- if a special decision of the orphan's court is made to protect the interests of the child by terminating the payment of the allowance to a person who is not actually caring for and raising the child.

- if custody rights are suspended or deprived of.

Monitoring arrangements

Data are stored in SSIA database. When necessary, the analysis of data is provided by SSIA, Ministry of Welfare

Financing agency

State Treasury

Sources of financing

State basic budget

Number of beneficiaries and refusals 2016 - 2019

Year	Beneficiaries[244]	Refusals[245]	
August 2019	2,273	I – IX 2019	50
January 2019	2,161		
2018	2,038		49
2017	2,053		44
2016	2,006		32

Spending on the benefit 2016 - 2019

Year	Spending in million EUR[246]
I - IX 2019	5,038
2018	5,417
2017	5,303
2016	5,262

[244] SSIA. "Budget and Statistics". November 2019. Available at: https://www.vsaa.gov.lv/par-vsaa/parmums/
[245] SSIA. Data on request.
[246] SSIA. Data on request.

3. State Social Security Benefit

Legislation that regulates it

The Law on State Social Allowances.[247] *Regulations Regarding the Amount of the State Social Security Benefit and Funeral Benefit, Procedures for the Review thereof and Procedures for the Granting and Disbursement of the Benefits.*[248]

Description of the benefit

State support in cash in a situation when additional expenditures are necessary or when a person is not able to obtain income.

Eligibility conditions

General requirements to receive state social benefit.

The benefit is granted to a person who does not have the right to receive the state pension (except the pension received by a disabled person for the loss of a provider) or insurance compensation for damages related to an occupational accident or occupational disease if a person is not employed (is not considered to be an employee or self-employed in accordance with the Law on State Social Insurance) [...] and has been recognized as a disabled person and is older than 18 years of age.

Regulating agency

Saeima / Cabinet of Ministers / Ministry of Welfare

Implementing agency

State Social Insurance Agency

The level of the benefit

For persons with disability since childhood EUR 106.72 (Disability Group III).

For persons with disability since childhood with Disability Group II EUR 128.06 (coefficient 1.3 is applied).

For persons with disability since childhood with Disability Group I EUR 138.74 (coefficient 1.4 is applied).

For persons with Disability Group I EUR 83.24.

For persons with Disability Group II EUR 76.84.

For persons with Disability Group III EUR 64.03.

Benefit duration and application renewal requirements

The benefit is granted for the established period of disability.

Renewal/continuation requirement: SMC decision on the determination of disability.

Administrative process and decision-making process to acquire the benefit

SMC determines disability and provides SSIA with digital information about the person with disability.

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[247] Ibid. (s.13), Riga: Saeima. Available at: https://likumi.lv/ta/id/68483-valsts-socialo-pabalstu-likums

[248] Regulations Regarding the Amount of the State Social Security Benefit and Funeral Benefit, Procedures for the Review thereof and Procedures for the Granting and Disbursement of the Benefits, 2009. SI 2009/1605. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/202850-noteikumi-par-valsts-sociala-nodrosinajuma-pabalsta-un-apbedisanas-pabalsta-apmeru-ta-parskatisanas-kartibu-un-pabalstu-pieskirsanas-un-izmaksas-kartibu

A person with disability applies to receive this benefit following general procedure.

The application is reviewed, and decision to grant/reject the benefit is made within a month after receiving the application.

Grievance and redress mechanisms

General procedures for appeal and contesting of decisions.

Benefit delivery/payment frequency

Once a month. The benefit may be received at place of residence (a fee for delivery is EUR 2.39) or transferred to the recipient's bank/ post system account.

The payment of the benefit is terminated:

- in general cases;

- if the term of disability has expired;

- if a person has the right to receive a state pension (except a survivor's pension for a disabled person) or insurance compensation due to an accident at work or an occupational disease.

Monitoring arrangements

Data are stored in SSIA database. When necessary, the analysis of data is provided by SSIA, Ministry of Welfare

Financing agency

State Treasury

Sources of financing

State basic budget

Number of beneficiaries 2016 -2019[249]

Year	Beneficiaries	Including persons with disabilities from childhood
August 2019	19,623	13,814
January 2019	19,730	13,894
2018	19,531	13,787
2017	19,538	13,712
2016	19,233	13,650

Spending on the benefit 2016 -2019

Year	Spending in million EUR[250]	Expenditures apply to all kinds of the state social security benefit, including to persons with disabilities.
I - IX 2019	17,924	
2018	24,791	
2017	23,850	
2016	22,655	

[249] SSIA. Data on request.
[250] SSIA. Data on request.

Table A9.1: Number of people with disabilities – recipients of the State Social Security Benefit by disability group and cause of disability

Year	Disability group I			Disability group II			Disability group III		
	Total number	From childhood	Other persons	Total number	From childhood	Other persons	Total number	From childhood	Other persons
2016	3,287	2,778	509	9,608	6,518	3,090	6,338	4,354	1,984
2017	3,398	2,864	534	9,660	6,476	3,184	6,480	4,372	2,108
2018	3,456	2,950	506	9,586	6,147	3,169	6,489	4,420	2,069
JAN 2019	3,530	3,010	520	9,598	6,391	3,207	6,602	4,493	2,109
AUG 2019	3,550	3,030	520	9,562	6,357	3,205	6,511	4,427	2,084

Source: State Social Insurance Agency, data on request.

4. Care Benefit for Person with Disability

Legislation that regulates it

Law on State Social Allowances.[251] *Regulations Regarding the Amount of an Allowance to a Disabled Person who Needs Care, Procedures for the Review of the Amount of an Allowance and Procedures for the Granting and Disbursement of an Allowance.*[252]

Description of the benefit

State support in cash in a situation when additional expenditures are necessary to a person with disability for whom SMC has issued an opinion on the necessity of special care.

Eligibility conditions

General requirements to receive state social benefit.

An adult person with disability who needs special care due to severe functioning disorders and an adult person with disability who needs special care due to severe functioning disorders and the cause of disability is a disease from childhood.

The right to benefit commences from the date on which SMC has issued an opinion on the need for special care.

Regulating agency

Saeima / Cabinet of Ministers / Ministry of Welfare

Implementing agency

State Social Insurance Agency

The level of the benefit

For disabled person who needs special care and whose cause of disability is a disease since childhood: EUR 313.43 (from July 2019) per month.

[251] Ibid. 2002. S. 12.1. https://likumi.lv/ta/id/68483-valsts-socialo-pabalstu-likums

[252] Regulations Regarding the Amount of an Allowance to a Disabled Person who Needs Care, Procedures for the Review of the Amount of an Allowance and Procedures for the Granting and Disbursement of an Allowance, 2009. SI 2009/1608. Riga: Cabinet of Ministers. Available at: https://likumi.lv/doc.php?id=202853

For disabled person who needs special care: EUR 213.43 per month

Benefit duration and application renewal requirements

The benefit is granted for the established period of disability and the necessity of special care.

Renewal/continuation requirement: SMC decision on the determination of disability and the necessity of special care.

Administrative process and decision-making process to acquire the benefit

SMC determines disability, provides an opinion on the necessity of special care and provides SSIA with digital information about the person with disability and necessity of special care.

The person must apply for the benefit.

The application is reviewed, and decision is made to grant/ reject the benefit within a month after receiving the application (with all documents and other information necessary to grant the benefit).

Grievance and redress mechanisms

General procedures for appeal and contesting of decisions.

Benefit delivery/payment frequency

Once a month by transfer to the recipient's bank/ post system account. It could also be delivered directly at the beneficiary's place of residence for a charge of EUR 2.39.

The payment of the benefit is terminated:

- in general cases;

- if the term of the disability and the necessity of special care have expired.

Monitoring arrangements

Data are stored in SSIA database. When necessary, the analysis of data is provided by SSIA, Ministry of Welfare

Financing agency

State Treasury

Sources of financing

State basic budget

Number of beneficiaries and refusals 2016 -2019

Year	Beneficiaries[253]	Refusals[254]	
August 2019	15,330	I-IX 2019	95
January 2019	15,427		
2018	15,226		104
2017	15,044		56
2016	14,293		67

[253] SSIA "Budget and Statistics". November 2019. Available at: https://www.vsaa.gov.lv/par-vsaa/parmums/.
[254] SSIA. Data on request.

Public spending on the benefit 2016 - 2019

Year	Spending in million EUR[255]
I - IX 2019	30,608
2018	40,973
2017	40,295
2016	37,852

5. Transport Allowance for Disabled Persons with Restricted Mobility

Legislation that regulates it

The Law on State Social Allowances.[256] *Regulations Regarding the Amount of the Allowance to Compensate Transport Expenses of Disabled Persons with Mobility Problems, the Procedure for Review Thereof, and the Procedures for Granting and Payment of the Allowance.*[257]

Description of the benefit

State support in cash in a situation when additional expenditures are necessary for the person with disability with restricted mobility to compensate transport expenses.

Eligibility conditions

General eligibility requirements for state social benefit.
Adult person with disability or a person whose child has disability and SMC has issued an opinion on the medical indications for the acquisition of a specially adjusted car and the receipt of an allowance for the compensation of transport expenses.
The right to benefit commences from the date on which SMC issued an opinion on the necessity of special care.

Regulating agency

Saeima / Cabinet of Ministers / Ministry of Welfare

Implementing agency

State Social Insurance Agency

The level of the benefit

EUR 79.68 for each six-month period.

Benefit duration and application renewal requirements

The benefit is granted for the established period of disability.

Renewal/continuation requirement - the SMC decision on the determination of disability.

Administrative process and decision-making process to acquire the benefit

SMC determines disability, provides an opinion on the necessity of special care and provides to SSIA digital information about the person with disability and opinion on the medical indications for

[255] SSIA. Data on request.
[256] Ibid. (s.12), Riga: Saeima. Available at: https://likumi.lv/ta/id/68483-valsts-socialo-pabalstu-likums
[257] Regulations Regarding the Amount of the Allowance to Compensate Transport Expenses of Disabled Persons with Mobility Problems, the Procedure for Review Thereof, and the Procedures for Granting and Payment of the Allowance, 2009. SI 2009/1606. Riga: Cabinet of Ministers. Available at: https://likumi.lv/doc.php?id=202851&from=off

the acquisition of a specially adjusted car and the receipt of an allowance for the compensation of transport expenses.
A person/one of the parents/guardians/foster parents submits an application according to general procedure.
The application is reviewed and decision to grant/ reject the allowance is made within a month after receiving the application (with all documents and other information necessary to grant the allowance).

Grievance and redress mechanisms

General procedures for appeal and contesting of decisions.

Benefit delivery/payment frequency

Twice a year for each complete six-month period counting from the day when the opinion of SMC was issued by transfer to the recipient's bank/ post system account. The benefit could also be delivered at the beneficiary's place of residence per request of the recipient for a fee of EUR 2.39.

The payment of the benefit is terminated:
- in general cases;
- if the term of disability has expired.

Monitoring arrangements

Data are stored in SSIA database. When necessary, the analysis of data is provided by SSIA, Ministry of Welfare

Financing agency

State Treasury

Sources of financing

State basic budget

Number of beneficiaries and refusals 2016-2019

Year	Beneficiaries[258]	Refusals[259]	
August 2019	29,132	I-IX 2019	119
January 2019	23,038		
2018	25,370		107
2017	24,098		61
2016	21,839		56

Spending on the benefit 2016-2019

Year	Spending in million EUR[260]
I - IX 2019	3,555
2018	4,590
2017	4,166
2016	3,888

[258] SSIA "Budget and Statistics". November 2019. Available at: https://www.vsaa.gov.lv/par-vsaa/parmums/
[259] SSIA. Data on request.
[260] SSIA. Data on request.

6. Benefit for Assistant Services for Persons with Group I Visual Disability

Legislation that regulates it

The Disability Law.[261] *Regulations Regarding the Benefit for Assistant Services for Persons with Group I Visual Disability.*[262]

Description of the benefit

State support in cash in a situation when additional expenditures are necessary for a person visual Disability Group I for assistant services.

Eligibility conditions

General requirements to receive state social benefit.

A person for whom SMC has determined Group I Visual Disability, who does not receive an assistant service in the municipality and who does not receive Care Benefit for Person with Disability.

The right to benefit commences from the date when the applicant for the benefit has submitted an application to SSIA.

Regulating agency

Saeima / Cabinet of Ministers / Ministry of Welfare

Implementing agency

State Social Insurance Agency

The level of the benefit

EUR 17.07 a week (for 10 hours a week).

Benefit duration and application renewal requirements

The benefit is granted for the established period for which Group I visual disability has been determined.

Renewal/continuation requirement - SMC decision on Group I visual disability.

Administrative process and decision-making process to acquire the benefit

SMC determines Group I visual disability and provides SSIA with digital information about the person.

A person must apply for the benefit according to general procedure.

The application is reviewed, and decision to grant/ decline the allowance is made within a month after receiving the application and documents.

Grievance and redress mechanisms

General procedures for appeal and contesting of decisions.

Benefit delivery/payment frequency

[261] The Disability Law 2010. (s.12 (1) 2). Riga: Saeima. Available at: https://likumi.lv/ta/id/211494-invaliditates-likums

[262] Regulations Regarding the Benefit for Assistance Services for Persons with Group I Visual Disability, 2014. SI 2014/698. Riga: Cabinet of Ministers. Available at: https://likumi.lv/ta/id/270262-noteikumi-par-pabalstu-par-asistenta-izmantosanu-personam-ar-i-grupas-redzes-invaliditati

Once a month for the previous month by transfer to the recipient's bank/ post system account.

Payment of the benefit is terminated in general cases; if disability term for Group I visual disability is terminated and for a period of time when the person has been in an in-patient hospital for a week, or is imprisoned.

Monitoring arrangements

Data are stored in SSIA database. When necessary, the analysis of data is provided by SSIA, Ministry of Welfare

Financing agency

State Treasury.

Sources of financing

State basic budget

Number of beneficiaries 2016-2019

Year	Beneficiaries[263]
August 2019	2,190
January 2019	2,195
2018	2,144
2017	2,100
2016	2,079

7. Support for persons involved in the mitigation of consequences after the Chernobyl NPS accident

7.1. Allowance for Persons Involved in the Mitigation of Consequences after the Chernobyl NPS accident

Legislation that regulates it

The Law on Social Protection of the Participants Involved in the Mitigation of Consequences After the Chernobyl Nuclear Power Station Accident and Persons Suffered due to the Chernobyl Nuclear Power Station Accident;[264] *Regulations on the State Social Allowance to the Participants Involved in the Mitigation of the Consequences of the Chernobyl Nuclear Power Station Accident and Families of Deceased Participants Involved in the Mitigation of the Consequences of the Chernobyl Nuclear Power Station Accident.*[265]

Description of the benefit

State support in cash in a situation when additional expenditures are necessary to participants involved in the mitigation of the consequences of the Chernobyl nuclear power station (NPS) accident and families of deceased participants.

[263] SSIA "Budget and Statistics". November 2019. Available at: https://www.vsaa.gov.lv/par-vsaa/parmums/

[264] The Law on Social Protection of Participants in the Mitigation of Consequences After the Chernobyl Nuclear Power Station Accident and Persons Suffered due to Chernobyl Nuclear Power Station Accident 1999. S. 11. Riga: Saeima. Available at: https://likumi.lv/doc.php?mode=DOC&id=17962

[265] Regulations on the State Social Allowance to Participants Involved in the Mitigation of Consequences After Chernobyl Nuclear Power Station Accident and Families of Deceased Participants Involved in the Mitigation of Consequences After the Chernobyl Nuclear Power Station Accident, 2010. SI 2014/698. Riga: Cabinet of Ministers. Available at: https://likumi.lv/doc.php?id=222142

Eligibility conditions

General requirements for state social allowances according to The Law on State Social Allowances.

A person to whom SMC has determined a disability in relation to the mitigation of consequences of the Chernobyl NPS accident.

One dependent child below 18 years of age (until 24 if the child studies full time at the secondary or higher education institution), spouse, parents and grandchildren of the deceased participant, if the cause of the death is related to the participation in the mitigation efforts.

An allowance is granted to a participant from the date of disability determination; to the family of the participant from the date of death of the participant.

Regulating agency

Saeima / Cabinet of Ministers / Ministry of Welfare

Implementing agency

State Social Insurance Agency

The level of the benefit

EUR 100.00 per month

Benefit duration and application renewal requirements

The allowance is granted for the established period of disability.

Renewal/continuation requirement: the SMC decision on disability.

To deceased participant's:

- child – from the date the child reaches 18 years of age, or 24 years of age if studying full-time at the secondary or higher education institution;

- grandchild – from the date the grandchild reaches 18 years of age;

- survived spouse – from the date s/he concludes another marriage or becomes a worker or self-employed.

Administrative process and decision-making process to acquire the benefit

1. SMC determines disability and causal link to the participation in the mitigation of consequences of the Chernobyl NPS accident. Provides the SSIA with digital information about the person.

A person must apply to receive the benefit.

2. Medical Commission of the Centre for Occupational and Radiation Medicine of P. Stradins Clinical University Hospital Ltd. issues an opinion that the cause of participant`s death is a disease linked to participation in the mitigation of the consequences of the Chernobyl NPS accident.

Provides SSIA with digital information about the person.

A judgment of the Court on the establishment of a condition of dependency has come into force. Court provides the SSIA with information.

Ministry of Education and Science provides SSIA with digital information about the person who studies in secondary education institution.

The application is reviewed, and decision to grant/ reject the application is made within a month after receiving the application and documents.

Grievance and redress mechanisms

General procedures for appeal and contesting of decisions.

Benefit delivery/payment frequency

Once a month by transfer to the recipient's bank/ post system account. The benefit may be delivered at the beneficiary's place of residence upon request of the recipient for a fee of EUR 2.39.

The payment of the benefit is terminated:

- in general cases;

- if the term of the disability has expired;

- for a child - upon reaching 18 years of age, or 24 years of age if studying full time at the secondary or higher education institution;

- for a grandchild – upon reaching 18 years of age;

- survived spouse – from the date when s/he concludes another marriage or becomes a worker or self-employed.

Monitoring arrangements

Data are stored in SSIA database. When necessary, the analysis of data is provided by SSIA, Ministry of Welfare

Financing agency

State Treasury

Sources of financing

State basic budget

Number of beneficiaries 2016-2019

Year	Beneficiaries[266]
August 2019	3,185
January 2019	3,232
2018	3,297
2017	3,379
2016	3,430

7.2. Compensation to a Person Involved in the Mitigation of the Consequences of the Chernobyl NPS Accident, who is Assigned a Degree of Incapacity for Work of 10 - 25%

Legislation that regulates it

The Law on Social Protection of Participants Involved in Mitigation of Consequences After Chernobyl Nuclear Power Station Accident and Persons Suffered due to Chernobyl Nuclear Power Station Accident. [267]

Description of the benefit

State support in cash for the participant involved in the mitigation of the consequences of the Chernobyl NPS accident, if they have lost work capacity 0-25%; in case of the persons death, former dependent family members incapable of work are entitled to receive the benefit.

[266] SSIA "Budget and Statistics". November 2019. Available at: https://www.vsaa.gov.lv/par-vsaa/parmums/
[267] Ibid. S. 11. Riga: Saeima. Available at: https://likumi.lv/doc.php?mode=DOC&id=17962

Eligibility conditions

- work incapacity is linked to the participation in the mitigation of the Chernobyl NPS accident consequences) (participant);

- participant for whom SCM has determined the loss of working abilities of 10-25%;

- deceased participant's dependent family members who are incapable to work and who have been granted a survivor`s pension according to Law on State Pensions.

Regulating agency

Saeima / Cabinet of Ministers / Ministry of Welfare

Implementing agency

State Social Insurance Agency

The level of the benefit

The compensation is calculated following a formula: 50% of the average insurance contribution wage in the previous calendar year in Latvia x loss of ability to work in percentage; for dependents - 50% of the average annual insurance contribution wage in the previous calendar year x the coefficient according to the number of family members who have been granted a survivor's pension. Coefficient 0.8 - if there is one dependent, 0.9 - if there are two dependents and 1.0 - if there are three and more dependents.

Benefit duration and application renewal requirements

Compensation is revised annually on May 1, taking into account the average insurance contribution wage for the preceding calendar year. The recalculation is made by SSIA.

A benefit is granted to a participant for the established period of disability or the time defined for the lost ability to work.

Renewal/continuation requirement - SMC decision on the work capacity % loss, change in the number of dependents.

Administrative process and decision-making process to acquire the benefit

SMC determines disability, lost ability to work expressed in percentage and causal link to the Chernobyl NPS accident. Provides to SSIA digital information about a person.

A person must apply to SSIA to receive this benefit.

The application is reviewed, and decision is made within a month after receiving the application and documents.

Grievance and redress mechanisms

General procedures for appeal and contesting decisions.

Benefit delivery/payment frequency

Once a month by transfer to the recipient's bank/postal system; at the beneficiary's place of residence per request of the recipient for a fee of EUR 2.39.

The Chernobyl mitigation participant with determined disability may at the same time receive a compensation and a state pension calculated and granted in accordance with the Law on State Pensions or compensation and the state social security benefit granted in accordance with the Law on State Social Allowances, or compensation and the service pension granted in accordance with special service pension regulations.

Monitoring arrangements

Data are stored in SSIA database. When necessary, the analysis of data is provided by SSIA, Ministry of Welfare

Financing agency

State Treasury

Sources of financing

For a participant of in the mitigation efforts – from the SSIA disability, maternity and sickness special budget; for dependent family members who are incapable to work in case of death of participant - from the SSIA state pension special budget; for participant for whom SCM has determined the loss of work capacity at 10-25% or dependent family members who are incapable to work in case of death of participant - from the state basic budget.

Number of beneficiaries 2016-2019*

Year	Beneficiaries[268]
I - IX 2019	2,400
2018	2,386
2017	1,284
2016	1,250

* Except where a pension has been granted in accordance with Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems or in accordance with international agreements binding on the Republic of Latvia.

8. Support in cases of Accident at Work or Occupational Disease

8.1. Insurance Indemnity Related to Accident at Work or Occupational Disease

Legislation that regulates it

The Law on Compulsory Social Insurance in Case of Accidents at Work and Occupational Diseases;[269] *Procedures for the Granting and Calculation of the Insurance Compensation from the Compulsory Social Insurance Due to Accidents at Work and Occupational Diseases.*[270]

Description of the benefit

Cash benefits to a person covered by mandatory state social insurance: if the person due to an accident at work (at the work place or while travelling to and from work in a vehicle owned by an employer) or an occupational disease has temporarily or permanently lost the ability to work or has died. In the event of death of the insured person, family members who have been dependent on the deceased are entitled to the survivor's benefits. The insured person is entitled to receive the following benefits: sickness benefit; compensation for the incapacity for work; compensation for additional expenses due to medical treatment and rehabilitation, care of a person, purchase and repair of special equipment, transportation costs for the visit to a doctor. In the event of death of an insured person as a result of an occupational accident or occupational disease, the members of the family are to the survivor's benefit and the funeral allowance.

Eligibility conditions

Entitled to the above benefits are employed persons who after 1 January 1997 have been insured against accidents at work and occupational diseases for at least 3 years.

The insurance benefits are triggered when the risk of injury at work/ occupational disease materializes. This fact must be formally established.

[268] SSIA "Budget and Statistics". November 2019. Available at: https://www.vsaa.gov.lv/par-vsaa/parmums/

[269] On Compulsory Social Insurance Related to Accidents at Work and Occupational Diseases 1995. Riga: Saeima. Available at: https://likumi.lv/ta/id/37968-par-obligato-socialo-apdrosinasanu-pret-nelaimes-gadijumiem-darba-un-arodslimibam

[270] Procedures for the Granting and Calculation of Insurance Compensation of Compulsory Social Insurance against Accidents at Work and Occupational Diseases, 1999. SI 1999/50. Riga: Cabinet of Ministers. https://likumi.lv/doc.php?id=21903

Compensation for the loss of capacity to work is not granted to persons with a loss of work capacity lower than 24%.

Regulating agency

Saeima / Cabinet of Ministers / Ministry of Welfare

Implementing agency

State Social Insurance Agency

The level of the benefit

The level of sickness benefit depends on the person's average insurance daily contribution wage x number of calendar days of incapacity to work x coefficient 0.8.

Compensation for the incapacity for work is calculated based on the person's monthly average insurance contribution wage and the percentage loss of work capacity. If the loss of ability to work is between 25% and 29%, compensation for the loss of ability to work is 35%, if the loss of ability to work is 100%, compensation is 80%, and in other cases if the loss of ability to work increases by 10%, the compensation will increase by 5%. A compensation for additional expenses is calculated based on the actual expenditures, for which receipts must be submitted.

The compensation is capped at twenty-five times social security benefit (see above) per month.

The funeral allowance is equal to the average monthly insurance contribution wage of the insured person; for the recipients of the compensation for the loss of capacity to work, it is double monthly insurance compensation of the deceased person.

The survivor's benefit depends on the average monthly insurance contribution wage of the insured deceased person, a person who will receive the benefit (a spouse or parents), number of children under 18 years of age and other conditions. Compensation should not exceed 80.0 per cent of the average monthly insurance contribution wage of the insured person and should not be less than the state social security benefit. The survivors benefit for each child should not be lower than the minimum amount determined by the Cabinet of Ministers.

Benefit duration and application renewal requirements

A sickness benefit is granted to a person for the established period of sickness. In case of an accident at work, the first 10 days of incapacity is paid by the employer, the rest by SSIA. If incapacity for work is related to an occupational disease, SSIA pays from the day the Medical Commission of the Centre for Occupational and Radiation Medicine of the P. Stradins Clinical University Hospital Ltd. has determined the occupational disease.

Compensation for the work incapacity: – for the period determined by SMC.

Compensation for additional expenses – lump-sum, post factum

Renewal/continuation requirement for compensation for the incapacity for work - SMC decision.

Administrative process and decision-making process to acquire the benefit

If insurance compensation is requested:

A person must apply and submit the following:

- A conclusion of the Medical Commission of the Centre of Occupational and Radiation Medicine of the P. Stradins Clinical University Hospital Ltd. on the occupational disease, relevant receipts to confirm expenditures;
  The State Labor Inspectorate electronically provides information regarding the accident that has occurred at work;

- SMC determines disability and the loss of ability to work in percentage. Provides to SSIA digital information.

The application is reviewed, and decision made within a month after receiving the application and documents.

Grievance and redress mechanisms

General procedures for appeal and contesting decisions.

Benefit delivery/payment frequency

Once a month by transfer to the recipient's bank/ postal system account, or at the beneficiary's place of residence for a fee of EUR 2.39.

The compensation for the loss of capacity to work and survivor's benefit are terminated when the recipient receives the unemployment benefit.

Monitoring arrangements

Data are stored in SSIA database. When necessary, the analysis of data is provided by SSIA, Ministry of Welfare

Financing agency

SSIA

Sources of financing

Mandatory social insurance contributions (special SSIA budget for disability, maternity and sickness benefits).

If the amount of the survivor's benefit for the child does not reach the minimum amount specified by the Cabinet of Ministers, the difference is covered from the state basic budget and paid from the state basic budget grant provided for in the Annual State Budget Law, which is included in the special budget for occupational accidents.

Number of beneficiaries 2016-2019

Year	Beneficiaries[271]
I - IX 2019	10,424
2018	9,987
2017	8,973
2016	8,541

8.2. Reimbursement of Medical Treatment Expenses Incurred Due to an Accident at Work or Occupational Disease

Legislation that regulates it

The Law on Compulsory Social Insurance in Case of Accidents at Work and Occupational Diseases.[272] *Procedures for the Granting and Calculation of the Insurance Compensation of the Compulsory Social Insurance in Case of Accidents at Work and Occupational Diseases.*[273]

Description of the benefit

[271] SSIA. Data on request.

[272] Ibid. https://likumi.lv/ta/id/37968-par-obligato-socialo-apdrosinasanu-pret-nelaimes-gadijumiem-darba-un-arodslimibam

[273] Ibid. https://likumi.lv/doc.php?id=21903

Benefit in cash to a person covered by mandatory social insurance to compensate additional medical treatment expenses, if these are not covered by the state.

In the field of health care, insured person has a right to receive additional compensation for treatment, purchase of medical products, including medicines, patient payments and medical manipulation, medical rehabilitation and travel expenses to visit medical facility.

Regarding social services, an insured person has the right to receive additional compensation for social rehabilitation, prosthetics, purchase and repair of technical aids, payment for accompanying person and vocational rehabilitation.

In the field of employment - requalification.

Eligibility conditions

Insured against accidents at work and occupational diseases for at least 3 years since 1997.

The insurance benefits are triggered when the risk of injury at work/ occupational disease materializes. This fact must be formally established.

Regulating agency

Saeima / Cabinet of Ministers / Ministry of Welfare

Implementing agency

State Social Insurance Agency

The level of the benefit

The amount of compensation equals eligible actual cost. The total amount of insurance compensation for treatment and rehabilitation costs should not exceed twenty-five times the state social security benefit on the day the insurance event took place (currently EUR 1,600.75).

Benefit duration and application renewal requirements

Compensation for additional expenses – lump-sum, post factum, not exceeding the maximum amount.

Compensation is paid up to the end of the period of disability, loss of capacity to work and special care requirements. Application renewal requirements – SMC decision and conclusion.

Administrative process and decision-making process to acquire the benefit

If insurance compensation is requested:

- a person applies to receive compensation according to a general procedure, submits application and documents – conclusion by the Medical Commission of the Centre for Occupational and Radiation Medicine of the P. Stradins Clinical University Hospital Ltd. on the determined occupational disease, receipts to prove expenditures;
- the State Labor Inspectorate electronically provides information regarding the accident at work;
- SMC determines the loss of ability to work in percentage. Provides to SSIA digital information;

The application is reviewed and decision made within a month after having received the application and documents.

Grievance and redress mechanisms

General procedures for appeal and contesting of decisions.

Benefit delivery/payment frequency

Compensation is paid by transfer to the recipient's account.

Monitoring arrangements

Data are stored in SSIA database. When necessary, the analysis of data is provided by SSIA, Ministry of Welfare

Financing agency

SSIA (from mandatory social insurance contributions)

Sources of financing

SSIA Special Accident Budget

Number of beneficiaries 2016-2019

Year	Beneficiaries[274]
I - IX 2019	5,571
2018	6,206
2017	6,030
2016	5,183

Spending 2016-2019

Year	Spending in million EUR[275]
I - IX 2019	1,038
2018	1,388
2017	1,415
2016	1,128

[274] State Social Insurance Agency. Data on request

[275] State Social Insurance Agency. Data on request.

ANNEX 9 - Social benefits of local governments

Riga city: Payment of transport services to persons with difficulty moving around and unable to use public transport

Legislation that regulates it

Law on Social Services and Social Assistance; On Procedure Regarding Payment of Transport Services to Persons with Functioning Impairments Unable to Use Public Transport.[276]

Description of the benefit

Material support for persons residing in the Riga City who do not receive long-term social care and social rehabilitation in an institution and are not imprisoned, have difficulty in moving around and are unable to use public transport.

Eligibility conditions

- persons to whom SMC has issued an opinion on the medical indications for the acquisition of a specially adjusted car and the receipt of an allowance for the compensation of transport expenses (persons with disability) to use specialized transport (mini bus), a taxi or to purchase a fuel;
- patients with chronic kidney failure requiring hemodialysis;
- persons who, for justified reasons, cannot use public transport, but who have not been issued SMC opinion, to travel to an and from an institution providing health care, rehabilitation, short-term social care and social rehabilitation services, as well as to travel to a long-term social care and social rehabilitation institution.

Regulating agency

Riga City Municipality

Implementing agency

Riga Social Service Office

The level of the benefit

For persons with disability – EUR 284.57 per year or EUR 23.72 per month. In addition, EUR 21.34 may be received if studying in an educational institution or attending long-term (for not less than one month) courses for obtaining or raising qualification, being employed, being a member of the board of a non-governmental organization, or EUR 71.14 per year if attending institutions to receive social, vocational or medical rehabilitation services.

For patients with chronic kidney failure – EUR 71.14 per month.

For persons who for justified reasons are not able to use cannot go by public transport – lump-sum transport service.

Benefit duration and application renewal requirements

For persons with disabilities - until the expiry of the term of validity of the opinion of the SMC.

[276] "On Procedure Regarding Payment of Transport Services to Persons with Functional Impairments Unable to Use Public Transport, 2018". Binding Regulations of the Riga City Council 2018/23. Available at: https://likumi.lv/ta/id/297208-par-transporta-pakalpojumu-samaksas-kartibu-personam-ar-funkcionaliem-traucejumiem-kuras-nevar-parvietoties-ar-sabiedrisko-transportu

For patients with chronic kidney failure – in conformity with the monthly list of persons submitted by the medical treatment institution.

Lump-sum allowance in defined cases (may be one or more times a year).

Administrative process and decision-making process to acquire the benefit

A person must apply to the Social Service Office and present a personal identification document. Additional documents to be submitted:

- for patients with chronic kidney failure, an extract from a hospital/outpatient medical card issued by a primary health care/treating physician stating the need and period for receiving procedures;
- for persons who, for justified reasons, cannot use transport - extract from a hospital/outpatient medical card issued by a primary health care/treating physician justifying the person`s inability to use public transport;
- for persons with disabilities who are studying, during the first semester of training, a document regarding admission to an educational establishment, but every six months thereafter, a statement from the educational establishment that the person has completed the previous semester of training and continues training or a copy of the contract for the commencement of training;
- for persons with disabilities who work, every six months a statement from the workplace indicating the duration of employment;
- for persons who, for justified reasons, cannot use public transport – a referral to a rehabilitation institution or a document confirming the period of rehabilitation service.

Documents can be submitted in person, by post or by electronic means with a secure electronic signature. The Social Service Office decides within 10 days.

Grievance and redress mechanisms

The decision of the Social Service Office can be appealed to the Welfare Department (WD) of the Riga City Council within one month from the date of the receipt of the Social Service Office decision; the decision of the WD of the Riga City Council can be appealed to the Administrative Court within one month from the date of receipt of the decision of the WD of the Riga City Council.

Benefit delivery/payment frequency

The benefit is transferred to a person with disabilities bank account once per quarter. For patients with chronic kidney failure - once per month. If, for objective reasons, a person is unable to get the payment trough the bank account, the benefit can be delivered in in cash.

Monitoring arrangements

Data are stored in SOPA database. When necessary, the analysis of data is provided by WD of the Riga City Council.

Financing agency

Riga City municipality

Sources of financing

Municipal budget

Number of beneficiaries 2016 - 2018	
Year	**Beneficiaries[277]**
2018	7,940
2017	7,389
2016	6,955
Spending on the benefit 2016 - 2018	
Year	**Spending in million EUR[278]**
2018	1,843
2017	1,733
2016	1,617

Ventspils: Allowance for pensioners and persons with disabilities for the purchase of medicines and medical devices

Legislation that regulates it

The Law on Social Services and Social Assistance; The Law on Local Governments;[279] On the Determination of the Status of a Low-Income Family (Person) and the Procedures for Receipt of the Local Government Social Benefits in Ventspils City.[280]

Description of the benefit

Material (cash) support for non-working pensioners and non-working persons with disabilities who have declared their place of residence on the administrative territory of Ventspils City and are reachable at the declared address in Ventspils City to partially cover the purchase of medicines, incontinence funds and stoma care goods.

Eligibility conditions

The allowance can be received by non-working persons with disabilities whose pension does not exceed EUR 338.00 per month (before taxes).

Regulating agency

Ventspils City Council

Implementing agency

Ventspils City Social Service Office

The level of the benefit

EUR 36.00 per year.

Benefit duration and application renewal requirements

The allowance is granted based on documents certifying expenditures during the current year, indicating the name of the applicant for the allowance, personal identity number, and products bought (medicinal products, incontinence funds or stoma care goods).

[277] Annual Report "Social system and health care in 2018", 2019. Riga: Riga City Council Welfare Department departaments. Available at: http://www.ld.riga.lv/lv/par-departamentu/par-mums/labklajibas-departamenta-gadagramatas.html /
[278] Ibid. http://www.ld.riga.lv/lv/par-departamentu/par-mums/labklajibas-departamenta-gadagramatas.html.
[279] The Law on Local Governments 1994. Riga: Saeima. Available at: https://likumi.lv/ta/id/57255-par-pasvaldibam
[280] "On the Determination of the Status of a Low-Income Family (Person) and the Procedures for the Receipt of Local Government Social Benefits in Ventspils City", 2018. Binding Regulations of Ventspils City Council 2018/8. Available at: https://likumi.lv/doc.php?id=245445

Administrative process and decision-making process to acquire the benefit

A person must apply to the Social Service Office and present a personal identification document. In addition, documents certifying expenditures must be presented as well. The Social Service Office decides within 10 days.

Grievance and redress mechanisms

Same procedure as in the case of the Riga City above.

Benefit delivery/payment frequency

The allowance is paid once per year to the account of the applicant or received at the Social Service Office cash-desk.

Monitoring arrangements

Data analysis is done by local government.

Financing agency

Ventspils City Council

Sources of financing

Municipal budget

Number of beneficiaries 2016 - 2018

No data are provided for persons with disabilities.

The total spending on the benefit for the years 2016 - 2018

No exact data are provided for disabled persons. The total amount of allowances for low-income pensioners and people with disabilities, as well as for pensioners and persons with disabilities whose income level does not exceed the level determined by Ventspils City Council was EUR 970 thousand in 2018 or 53% of the total funds spent on social assistance and social services.

Valka: Apartment (housing) and fuel allowance

Legislation that regulates it

The Law on Social Services and Social Assistance; The Law on Assistance to Solving Apartment Matters;[281] *Apartment (housing) allowance in the Valka municipality.*[282]

Description of the benefit

Material support for a single person with disabilities who has declared his or her place of residence in the territory of Valka municipality in order to partially cover the rental (management) costs and public costs of an apartment (housing) (not exceeding the actual costs) or fuel costs.

Eligibility conditions

An apartment allowance may be received by a single person with disabilities (unemployed, living separately from legitimate survivors or without legal survivors, whose income does not exceed 75% of the national minimum wage, and whose movable and immovable property is assessed in accordance with the Cabinet of Ministers regulations and the binding regulations of the local

[281] The Law On Assistance to Solving Apartment Matters 2001. (s.25 (10), Riga: Saiema. Available at: https://likumi.lv/ta/id/56812-par-palidzibu-dzivokla-jautajumu-risinasana

[282] "Apartment (housing) allowance in Valka municipality", 2012. Binding Regulations of Valka municipality 2012/23. Available at: http://www.valka.lv/wp-content/uploads/2011/11/saist_not_nr23_2012.pdf

government regarding the procedures by which a person (family) is recognized as needy). The allowance is granted for an apartment/housing in which the person resides, and it is not rented out to gain income.

The fuel allowance may be received by a single person with a disability who lives in a dwelling (apartment) heated with wood and is the owner of a dwelling (apartment), or who has a rental agreement with the owner of a dwelling (apartment). During a calendar year a person may receive one of the listed allowances.

Regulating agency

Valka Municipality Council

Implementing agency

Valka Social Service Office

The level of the benefit

EUR 25.00 per month; for fuel allowance - EUR 60 per year.

Benefit duration and application renewal requirements

Allowance is granted based on an application.

Application renewal requirements – new application.

Administrative process and decision-making process to acquire the benefit

A person must apply to the Social Service Office and present a personal identification document. The Social Service Office decides within 10 working days.

Grievance and redress mechanisms

The decision by a social work specialist of the Social Service Office may be appealed to the Head of the Social Service Office within the time limit specified in the decision. The decision of the Head of Social Service Office may be appealed to the Administrative District Court in accordance with the procedures specified in the Law.

Benefit delivery/payment frequency

The housing allowance is granted for a period of six months. The fuel allowance is granted and paid once a year.

Housing allowance shall be transferred to the account of the apartment manager (if the apartment manager is a legal person) or the account of the requester of the allowance or shall be paid (if the apartment manager is a natural person).

The fuel allowance shall be transferred to the account of the applicant for the allowance or paid to the applicant for the allowance.

Monitoring arrangements

No information available.

Financing agency

Valka municipality Council

Sources of financing

Municipal budget

Number of beneficiaries 2016 - 2018

No exact data are provided for persons with disabilities. In total, 687 persons received housing allowance in 2018; and 737 persons in 2017.[283]

Spending on the benefit 2016 - 2018

No exact data are provided for persons with disabilities. Total amount of apartment (housing) allowance was EUR 85,658 in 2018 and EUR 82,086 in 2017.[284]

Dagda municipality: Benefits for paying services to pensioners, disability pension beneficiaries.

Legislation that regulates it

The Law on Social Services and Social Assistance; The Law on Local Governments;[285] Regulations on Social Assistance in Dagda municipality;[286]

Description of the benefit

Material support for a needy or low-income persons with disabilities in order to partially cover basic needs - the cost of boarding and lodging in medical, social rehabilitation, crisis centers and other institutions, and the cost of physical and mental health care in accordance with defined co-participation measures and/or social rehabilitation plans.

Eligibility conditions

Needy person with disabilities (income level of EUR 128.06 per month per person) or a low-income person with disabilities (income level EUR 200 per month per person) who lives alone and who has declared a basic residence on the administrative territory of Dagda municipality.

Regulating agency

Dagda municipality Council

Implementing agency

Dagda Social Service Office

The level of the benefit

EUR 150 per year.

Benefit duration and application renewal requirements

The benefit is granted based on the application and supporting documents. Application renewal requirements – new application.

Administrative process and decision-making process to acquire the benefit

A person must apply to the Social Service Office. The Social Service Office evaluates the application and the social situation of the person The Social Service Office decides based on an opinion of a social work specialist on a positive cooperation with a person for the achievement of social rehabilitation objectives and/or a justified need to meet the basic needs of a person.

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[283] Annual Public Report 2018 of the Valka municipality, 2019. Valka: Valkas municipality Council. Available at: http://www.valka.lv/wp-content/vnd_gada_parskats.pdf

[284] Ibid. http://www.valka.lv/wp-content/vnd_gada_parskats.pdf

[285] The Law on Local Governments 1994. S. 43 p.3. Riga: Saeima. Available at: https://likumi.lv/ta/id/57255-par-pasvaldibam

[286] "On the Social Assistance in Dagda municipality", 2017. Binding Regulations of Dagda municipality 2017/8. Available at: http://www.dagda.lv/fileadmin/Pasvaldiba/Saistosie_noteikumi/2017/SN_Nr.8_par_soc.palidzibu.pdf

Grievance and redress mechanisms
The decision of the Social Service Office may be appealed to the Dagda Municipality Council. The decision taken by the Dagda Municipality Council may be appealed in accordance with the procedures specified in the Administrative Procedure Law.
Benefit delivery/payment frequency
The benefit is paid to the person's bank/post system account.
Monitoring arrangements
No information available.
Financing agency
Dagda municipality Council
Sources of financing
Municipal budget
Number of beneficiaries 2016 - 2018
No separate data are provided for persons with disabilities
Spending on benefit 2016 - 2018
No exact data are provided for persons with disabilities. The total expenditure on social benefits for 2018 is EUR 453,691 or 5.1% of the total expenditure on the basic municipal budget. Compared to 2017 (EUR 484,820), these expenses have fallen by 6.4%.[287]

[287] Annual Public Report of Dagda municipality 2018, 2019. Dagda: Dagda municipality Council. Available at: http://www.dagda.lv/uploads/media/DAGDAS_NOVADA_PGP_2018.pdf

ANNEX 10 - Determination of vocational suitability at SISA

Persons with disabilities or with a predictable disability may have their vocational suitability (VS) assessed. The assessment can be recommended by a family doctor, social worker or SMC,[288] or a person can be referred by PES, if s/he has registered with PES as unemployed.

Initially, this service was the service was provided under the ESF project "Support for the long-term unemployed" (2017-2020) with a duration of 10 working days to the unemployed persons with disabilities, persons with a predictable disability and persons with health problems, based on a referral by PES. From 2020, the service is provided only for the unemployed with disabilities and a predictable disability referred by PES within the program "Subsidized Jobs for the Unemployed" with a duration of 5 working days.

Vocational suitability is determined by a team of specialists: a psychologist, a career advisor, a social worker, a medical doctor, an occupational therapist, a physiotherapist, a psychiatrist and a pedagogue. The team identifies/assesses the person's professional interests; possible professions; vocational training programs; motivation to engage in the labor market and to learn; health suitability for the acquired or selected profession; intellectual capacity to participate in training and the labor market; psychophysiological characteristics and their match with the chosen profession; assess past knowledge and experience of the unemployed person; ability to learn, understand, perceive and memorize new information. Based on the assessment the team prepares recommendations on the appropriate work and appropriate active employment programs, which a person can access through PES.

The average cost of the VS assessment increased from EUR 352.0 in 2017 to EUR 506.0 in 2019 or by 43.0%. The number of persons with disabilities receiving the service increased from 182 (or 2.0% of 8,234 persons with disabilities registered in PES) in 2017 to 276 in 2019 (or 3.5% of 7,780 persons with disabilities registered in PES) or by 51.0% but is nevertheless very small. In total 726 disabled unemployed persons were assessed for vocational suitability over the last several years, of whom only 63 found a job within 6 months. Others participated in other activities of PES (training, subsidized jobs, etc.).

Given that the number of unemployed disabled people who are assessed by SISA for vocational suitability is small and that very few (9.0 percent) find a job within six months after the assessment, MOW should evaluate the service and look for an alternative way of doing the assessment (does a person need to stay at the facility for 5 days to be assessed?). Normally, this should be done by PES through aptitude, matching and profiling tools applied by a PES employment counsellor.

[288] A vocational suitability service is legally regulated in the *Law on Social Services and Social Assistance* as part of a vocational rehabilitation service. (*Law on Social services and Social Assistance*, 2002. s.1, s.26. Riga: Saeima. Available at: https://likumi.lv/ta/id/68488-socialo-pakalpojumu-un-socialas-palidzibas-likums)

ANNEX 11: Active employment measures[289]

Career consultations: Persons with disabilities have access to Public Employment Service (PES) organized **career consultations** for individuals (usually one hour) and groups (usually three hours) where they can be taught to draft a CV, write a letter of motivation, prepare for a job interview, determining vocational suitability, assessing options for successful career change, learning about career and the choice of profession; and be informed about the situation and trends in the labor market. Examples of various documents (CV, Europass CV, motivation letter), short-term forecasts of the labor market, CV and vacancy portal and a manual for a job search are available on the PES website.[290]

Vocational training, requalification, qualification improvement: a person with disability can receive a training voucher for the acquisition of a further vocational education program to obtain vocational qualification or the acquisition of a vocational training program in order to improve his or her professional skills and to acquire professional knowledge and skills that meet the requirements of the labor market. A person with disability may choose an educational program from the list of training areas and occupations approved by MOW and an educational institution. The program for further vocational education or vocational improvement may be selected from the lists of PES programs, but the educational establishment may be selected independently by a person or from the PES list. The duration of training is up to eight months with a grant of EUR 5.00 per training day. At the same time, it is possible to receive financial contribution of up to EUR 150.00 per month to cover transport cost and a compensation for the rental of accommodation or a service hotel.[291]

Paid temporary public works: Temporary public works are organized by local governments or NGOs (associations and foundations) on a non-profit basis for a period of up to four months per year. Participants are paid EUR 200.00 per month plus mandatory state social insurance contribution. Health examinations provided for in regulatory enactments are also covered (not more than EUR 30.00 per participant). A monthly grant for one coordinator of paid temporary public works in the local government of EUR 150.00 is paid in proportion to the worked working days.

Programs to increase competitiveness: a disabled person can develop social and functional skills, receive psychological support, acquire basic skills and skills needed for the labor market, learn about job search methods, non-formal education (including to learn Latvian, financial literacy, preparing a letter of motivation and preparing for a job interview, skills needed to work with computers and the Internet, etc.), as well as participation in other activities organized by PES to boost competitiveness in the labor market.

Program to support the start of commercial activity or self-employment: Persons with disabilities may receive advice for the preparation and development of a business plan[292] as part of support to start commercial activity or self-employment; if the plan is assessed as viable, they can receive further counselling and financial support.[293] To participate, a person with disabilities should have appropriate vocational secondary education or higher education in the field of business, business management or

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[289] Description prepared on the basis of the Cabinet Regulations No 75 (2011) *Regulations Regarding the Procedures for Organising and Financing of Active Employment Measures and Preventative Measures for Unemployment Reduction and Principles for Selection of Implementers of Measures* and information from the PES home page https://www.nva.gov.lv/.

[290] https://www.nva.gov.lv/index.php?cid=433&mid=666

[291] Transport expenditure and compensation are financed under the "Support for regional mobility under active employment measures".

[292] 20 consultations during 6 weeks.

[293] 20 consultations, not more than EUR 5000.0 for the implementation of the business plan and EUR 430 per month for the first six months of te plan implementation.

other comparable fields or in which a commercial or self-employment activity is to be commenced, have acquired vocational education programs, which provide the necessary knowledge in the field of business management or in the field in which commercial activity or self-employment is planned; or have obtained secondary vocational education or higher education and have acquired a non-formal education program (not less than 120 academic hours) in the field of business management.

Job search support measures include the development of an individual job search plan for the unemployed, profiling of the unemployed, identifying a suitable work, informing about the job search methods, monitoring the performance of the job search obligation and measures promoting job search.

Subsidized employment and support to specific groups of persons with disabilities. These programs include employment in subsidized and, if necessary, adjusted workplace, for a specific period - two years. The program is funded by the European Social Fund (ESF). An employer may receive a salary grant (the size of which depends on the regulation under which the aid is provided),[294] a grant of 50.0% of the national monthly minimum wage for the remuneration of the work manager, a one-off grant for the purchase of equipment and facilities and the costs of manufacturing and purchasing technical aids, and for adjustment of the work place for the unemployed person with disability.

If the aid is provided within the framework of the Commission Regulation 1407/2013 (*de minimis* aid) and the employer is an association/foundation whose activity aims at providing aid to persons with disabilities or assistance to persons with visual disabilities, the employer when employing persons with disabilities in certain professions[295] is entitled to receive a grant for the state social insurance contributions for the subsidized part of the wage. If the employer concludes an employment contract for an indefinite period, PES will provide a grant of up to EUR 711.0 for the adjustment of one workplace[296] and a monthly grant of 50.0% of the national minimum monthly wage[297] in proportion to the work days of the disabled person per month.[298] At the beginning of work people with hearing disabilities may receive a sign-language interpreter service of direct translation of up to 40 hours per week, while persons with mental disabilities can receive a support person`s services for a period of 12 months.[299]

Work practice at the workplace provides an opportunity to determine vocational suitability and for a person with disabilities to practice a specific job with a specific employer.

Training (apprenticeship) with an employer is practical training of an employee organized by the employer. The duration of practical training is six months, provided that an employment contract is

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[294] The grant for the salary of the disabled worker in the amount of the minimum monthly wage for low-skilled jobs covers the Commission Regulation 1407/2013 (*de minimis* aid) and the Commission Regulation 651/2014. For the performance of other works the Commission Regulation 1407/2013 (*de minimis* aid) includes the grant for wages and salaries up to and including a minimum monthly wage, but the Commission Regulation 651/2014 includes the amount of the grant for the salary of the disabled worker at 75% of the monthly wage to be paid taking into account that the monthly salary grant for normal working time is not more than one and a half of the national monthly minimum wage.

[295] An assistant or an accompanying person for persons with disabilities, a sign language interpreter, an interpreter of the Latvian sign language, an educator of the interest group and a special educator or profession which is included in the list of specially created commissions.

[296] The workplace will be assessed and an opinion on the compliance of the workplace and the technical aids needed to adapt the workplace provided by an ergotherapist selected by PES.

[297] During 2018- 2019 the minimum monthly wage was EUR 430.

[298] Support is provided during the first or first two months of of formal employment.

[299] During the first week of formal employment the support person's service is available every full working day; from the second to the fifth week - each work day, but not more than three hours per day; from the sixth to the ninth week - twice per week, but not more than one hour per day; and from the tenth week onwards - once a week, but not more than one hour.

concluded, and the employment relationship is subsequently continued for at least 3 months.[300] Practical training includes acquisition of professional competences corresponding to professional competences of the first, second or third level of professional qualification. It is not organized for unskilled and low-skilled jobs. Practical training may be carried out by merchants, self-employed persons and NGOs (associations or foundations).[301] Under the program, an employer is entitled to a monthly salary grant (EUR 200.0 for the first three months and EUR 150.0 for the last three months), a monthly salary grant for a job manager (who can manage a maximum of two trainees) of 50% of the minimum monthly wage, a lump-sum grant for personal protective equipment of not more than EUR 100.0 and a one-off grant for adapting the workplace up to EUR 711.0 per workplace for a person with disability. The cost of mandatory health checkup is also covered up to EUR 30.0. An association or foundation whose operational purpose is to provide assistance to persons with disabilities or persons with visual disabilities[302] is entitled to receive a grant for mandatory state social insurance contributions, provided that the total number of employed unemployed persons does not exceed 50.0% of the total number of employees of the association or foundation.

Programs financed by the ESF:

"*Subsidized workplaces for the unemployed*", in addition to subsidized workplaces:

- PES organizes consultations for employers on the specific nature of communication and employment of unemployed persons with disabilities according to the type of disability (mobility, visual, hearing, mental (including communication with persons with mental disabilities), etc.; lessening of communication barriers and stereotypes/ prejudice among staff; resolution of conflicts and problem situations; and other topical issues related to the promotion of employment of people with disabilities.
- Unemployed persons with disabilities and addiction problems (alcohol, narcotic or psychotropic addictions or behavioral problems) can receive an opinion from a drug abuse specialist, participate in the Minnesota 12-step program and get emotional stress therapy (coding).
- Persons with disabilities[303] are entitled to individual counselling from a psychologist.
- Persons with disabilities or with a predictable disability are entitled to a service for determining vocational suitability at the Social Integration State Agency (SISA). Within the service a team of specialists through individual interviews and group work identifies the person's professional interests; specific professions; vocational training programs; motivation to engage in the labor market and to learn; health suitability for the acquired or selected profession; intellectual capacity to participate in training and the labor market; psychophysiological characteristics and their match with the chosen profession; assess past knowledge and experience of the unemployed person; ability to learn, understand, perceive and memorize new information. Transport, catering and accommodation within the service is provided at the service hotel.
- Persons with disabilities who have been unemployed for more than 12 months are entitled to participate in activation measures and to receive services of a social mentor for up to seven months, if after getting a job, the specified trial period has expired. Motivation measures, support

[300] The employer should provide a newly created workplace or a workplace sould have been vacant for at least 4 months prior to the commencement of practical training, and the unemployed person concerned has not been employed with the relevant employer for at least 12 months prior to the participation in practical training.

[301] The regulatory framework provides that training cannot be carried out by medical treatment institutions, educational institutions whose primary purpose is the implementation of educational programs and political parties.

[302] A grant may be received if an employee is employed in the following professions - an assistant or an accompanying person for persons with disabilities, a sign language interpreter, a Latvian sign language interpreter, an educator of the interest group and a special educator or a profession, which is included in the list of especially formed commission.

[303] Persons who have been unemployed for at least 12 months and have not been workers or self-employed during that period for more than two months without interruption.

and counselling to address individual social problems (motivational program) in a group classes are set at 80 academic hours. Social mentor services are provided for 40 hours a week. As part of the program it is possible for a disabled person to participate in individual and group activities, get psychological support, and a sign language interpretation service. During the training specialist assistants are provided, as well.

"*Support for education of the unemployed*" for persons with disabilities:

- There are two e-training modules on financial literacy and the preparation of a letter of motivation and preparation for a job interview.
- Financial compensation for the assessment of professional competence acquired outside formal education system.

"*Support for the long-term unemployed*" persons (including disabled persons) who have been unemployed for more than 12 months and persons who have refused at least once a suitable job offer or have refused to participate in the active employment programs provided for in the individual employment plan may participate in the work motivation program (group lessons) and then receive mentor's services (individual counselling). Psychological and practical support is provided for a maximum of 3 months.

Program to promote regional mobility of employed persons. The program includes financial compensation of up to EUR 600.0, and reimbursement of transport cost and accommodation rental cost. Financial support should be requested within 10 working days from the date of employment, provided that the following conditions are met: the person should had had a status of the unemployed for at least two months prior to the employment; the employer had registered a vacancy with PES in the same profession/job the employed person had had; the place of employment is at least 15 km from the declared place of residence were the person had been registered for at least six months or s/he had changed the registered place of residence during the last six months and both new and the previous place of residence are situated in the administrative territory of one local government; the employer does not provide for the costs of travel or residential space; the employment is permanent and not for less than 8 months, and the salary is at least at the level of the minimum monthly wage but does not exceed two monthly minimum wages.

PES programs may be implemented separately or in combination, taking into account specific needs of a disabled person.

ANNEX 12: List of interviews conducted for the study and sources of statistical information

In this report qualitative and quantitative research methods were used, including analysis of legal acts, expert interviews, and statistical data analysis.

The interviews were conducted with:

- Representatives of the Social Inclusion Policy Department of the Ministry of Welfare (MOW), concerning the Project objectives and the results to be achieved;
- Representatives of the Labor Market Policy Department of MOW, concerning labor market policy and support measures for persons with disabilities;
- Representatives of the State Medical Commission for the Assessment of Health Condition and Working ability of Latvia (SMC):
  i. Deputy Head of the SMC, regarding disability and work capacity determination process;
  ii. IT Systems Security Manager, regarding the functionality and capabilities of the current IT system;
  iii. European Regional Development Fund (ERDF) Project Manager, regarding future IT system functionality and capabilities;
- Deputy Director for Information and Communication Technologies (ICT) and Deputy Head of ICT Project Development Unit of the National Health Service (NHS), concerning possible cross-system integration between the SMC DIS system and the single health information system (E-Health) maintained by the NHS;
- Representatives of the Public Employment Service, concerning support measures for persons with disabilities and procedure for provision of support.

The following data sources were used:

- Eurostat data from the European Health and Social Integration Survey (EHSIS);
- Eurostat data from the European Union Labour Force Survey (EU-LFS);
- Central Statistical Bureau of Latvia (CSB);
- MOW (LabIS);
- SMC;
- State Social Insurance Agency (SSIA);
- Social Integration State Agency (SISA);
- PES.